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Health and welfare in transition

A report on the Maputo Conference April 1990

• Published by Critical Health and the Maputo Conference Co-ordinating Committee •

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Editorial

With the new latitude provided by the unbanning of political organisations early this year and with the real possibility of transfer of power, progressive organisations in South Africa are facing the urgent need to give substance to the many demands and aspirations that have been expressed through the years of apartheid domination. Slogans such as "health care for all" and demands for a national health service must now be addressed in real terms. We are faced with the task of giving life to such ideals and expectations, given the limited resources available for the transformation of health and welfare services.

In April this year, a conference was held in Maputo, Mozambique which looked at the transition of health and welfare towards a new South Africa. The conference enabled the various organisations present to debate the options facing us in this period of transformation. Possible short, medium and long term strategies to achieve an equitable, accessible and appropriate health and welfare service were discussed.

The conference addressed the restructuring, financing and personnel choices involved in the process of transition. Special workshops were held on the way forward for women, occupational health, and family and children as well as a session on preparations for the health and welfare of returnees.

Two days of the week long conference were devoted to addressing the issue of AIDS in South Africa, recognising the urgent need for a progressive approach to the epidemic .

Options in Health Sciences Education - working towards integrated community-based training of health and welfare personnel in order to make education more appropriate to the needs of the people served - were also debated over two days. The resolutions adopted by the conference on these issues are included in this report.

There was significant participation of the Frontline States at the conference. Representatives from Namibia, Angola, Mozambique and Zambia gave inputs on the problems they faced in the transformation of health and welfare services since their independence.

Holding the conference in Mozambique was an expression of solidarity between the progressive forces in South Africa and Mozambique as well as the rest of Southern Africa. The conference noted the immeasurable damage caused by the South African government's involvement in the destablisation of Mozambique and stressed the common vision for peace and "progressive" co-operation in the region.

This double edition of *Critical Health* was produced jointly by the *Critical Health* Editorial Collective and the organisations within South Africa which helped co-ordinate the conference*. A vast number of papers were presented at the conference, not all of which are included in this report. The report aims to bring the core message of the conference to as many people as possible rather than to provide a detailed conference proceedings. It attempts to reflect the range of opinion emerging from the conference and does not necessarily reflect the views of this editorial collective.

This International Conference on Health and Welfare in Southern Africa was initiated by the US based Committee for Health in Southern Africa (CHISA). Prior to this, CHISA had organised three previous international conferences, held in North America. This conference, however, was historic in that it was jointly organised by the Ministry of Health, Maputo, the African National Congress (ANC), progressive health and welfare organisations in South Africa, representatives from the Anti-Apartheid Movement in the UK, CHISA and the WHO Collaborative Centre for Community Based Health Sciences Education of the University of New Mexico.

* NEHAWU, NAMDA, SAHWCO, OASSSA and the Welfare Co-ordinating Committee (consisting of SABSWA, CSW, Social Workers Forum, The Durban Welfare Policy Group).

Acknowledgements

Special thanks due to Kamy Chetty for the co-ordination of the conference and thanks to all those delegates who assisted in writing up the overviews and special issue workshop reports included in this edition. Thanks also to the International Development Research Centre (IDRC) for assistance with the additional printing costs involved in bringing out this edition.

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Declaration on health and welfare in Southern Africa

Maputo, April 15, 1990

This Maputo Conference, an International Conference on Health in Southern Africa, held between April 9-15, 1990, has been a unique and unprecedented event at a moment of historic opportunity for the liberation struggle.

This meeting has had a special and remarkable character for three reasons.

1. It has brought together for the first time health and social welfare workers, anti-apartheid activists from the United States of America, the United Kingdom and other countries, organisations representing more than 54 000 health workers from within South Africa, and their counterparts and comrades from the ANC, Mozambique and all of the Frontline States.

2. It has addressed the urgent challenge, in this final and decisive stage of the liberation struggle, of formulating specific proposals, strategies and policies for the structure, organisation, financing and development of health and welfare services for a truly democratic South Africa.

3. Of further political significance, the Maputo Conference has been an expression of the Mozambique government's solidarity with progressive forces in South Africa, a recognition of our shared experience of the tyranny of apartheid and our mutual abhorrence of the deliberate destabilisation of Mozambique, and in particular of the appalling atrocities perpetrated by the apartheid regime. This shared experience - including the deliberate apartheid effort, both within and outside South Africa, to destroy the potential for full development of entire generations - united us as brothers and sisters.

This conference commits itself to:

- Transforming the existing health and social services in South Africa into a non-racial, accessible, equitable, cost-effective and democratic national health and welfare system.
- Promoting a new vision of health and welfare services as a tool of national development.
- Devising an appropriate social welfare policy for a future South Africa and to placing the development of this policy high on the agenda of the national liberation movement.
- Prioritising the development of a progressive primary care strategy as the basis for the provision of health and welfare services.
- Emphasising the importance of making realistic assessments of the resources required to meet national health and welfare needs equitably, and of researching means for mobilising such resources.

In line with the above commitments, high priority must be placed on applied health and welfare research and training. Communities, political organisations and research groupings should be mobilised to achieve this in the shortest possible time.

The conference devoted particular attention to the problems of financing future national health and welfare systems in South Africa, and recognised the need for further research. These debates need to be placed in the context of the specific characteristics of a mixed economy. Discussions around the role of the private health and welfare sector should be extended through health and community organisations, taking cognisance of effective international models.

Adequate primary health care and welfare services will require appropriate personnel. The conference stressed the need for research and training, for the integration of ANC health workers at every level into the health sector, and for understanding of the role of traditional healers.

The participants are unanimous in their belief that the training and education of health and welfare workers is most effective and appropriate when it is situated in the community, and achieved through problem-based learning methods. The problems of accredition of health professionals trained by different methods and through different institutions both within and outside South Africa, has to be addressed with the relevant authorities in order to maximise opportunities for employment of these individuals.

All delegates to the conference benefitted considerably from presentations of experiences in health and welfare services in the Frontline States. Some of these experiences, which have a direct bearing on the reconstruction of South Africa's health and social services, must be more fully explored. Everyone is fully committed to enhancing the quality of life of all the people of the Southern African subcontinent through regional cooperative endeavours, which would be encouraged and established once South Africa has obtained independence, democracy and freedom.

A number of issues of urgent priority were identified. This conference affirms the need to integrate women into all health and welfare initiatives, and points out that every proposal must specifically examine the consequences for women. The conference takes particular cognisance of the needs of children and families, and the damage that has been done to them by apartheid. That damage must be reversed. The worth and dignity of family life must

be restored. Childhood must be reclaimed. The conference stresses the importance of the health and welfare of workers, not only on the factory floor and the rural farm, but also in relation to the appalling community and environmental conditions which must be massively improved. To address the urgent problem of the return to South Africa of more than 20 000 exiles, the conference endorses the formation of a National Reception Committee, through which the ANC together with other progressive mass-based organisations, can work out concrete measures for the rapid and effective integration of returnees into South African social, political and economic life.

All those present are acutely aware that South Africa and indeed the entire Southern African region is facing a crisis over the HIV epidemic. Urgent action must be initiated immediately, as the State's programmes are fundamentally limited and seriously flawed. Community-based initiatives are known to be more effective since they pay attention to the broader psycho-social implications of the disease. An alternative progressive campaign with the support of political and other representative organisations has to be set up immediately. An AIDS Task Force with strong political leadership is proposed to take this programme forward.

Finally, this Conference expresses our hope, our determination and our confidence.

Our hope is derived from the fact that all the nations in the region are accomplishing the complete decolonisation of the subcontinent of Southern Africa. The independence of Namibia is a recent example.

Our determination is to eradicate the last vestiges of racial oppression and colonial exploitation from the entire region.

Our confidence stems from our capacity for unity which has been affirmed by the common sense of purpose which has brought together people from many nations, many origins and backgrounds, and many disciplines to address the short and longer-term tasks of charting the future of a truly democratic South Africa. ❑

Delegates to the Maputo Conference.

Issued by the Conference Organising Groups:

The African National Congress; National Education Health and Allied Workers Union, National Medical and Dental Association; Organisation for Appropriate Social Services in South Africa; South African Health Workers Congress; Welfare Coordinating Committee; Ministry of Health, Mozambique; Committee for Health in Southern Africa (USA); Representatives from the WHO Collaborating Centre for Community Based Medical Education at the University of New Mexico; Anti-Apartheid Movement (London).

Other participants were:
The Deans of the medical schools of the Universities of: Edouard Mondlane, Mozambique; Ilorin, Nigeria; Newcastle, Australia; Zambia.
Representatives from the Frontline States: Angola, Namibia, Tanzania, Zambia.
Representatives from FRELIMO, the WHO representative, Maputo; other Mozambican participants.
Representatives from the following internal South African organisations:
Congress of South African Trade Unions - health and safety group; Concerned Social Workers; Critical Health publication; Health Workers Society; Health Workers Union; Industrial Health and Safety Service Organisations; Islamic Medical Association; National Interim Women's Group; National Union of Students; Progressive Primary Health Care Network; Social Workers Forum; South African Black Social Workers Association; South African Council of Churches; South African National Students Congress; United Democratic Front.

Keynote address

By Comrade Walter Seathe, ANC Chief Representative in Maputo

Your Excellency the Minister of Health of the People's Republic of Mozambique, Comrade Chair, Compatriots, Comrades and Friends.

This Fourth International Conference on Health in Southern Africa could not be taking place at a more appropriate moment. Bringing together as it does the ANC and the major democratic organisations involved in health and social welfare work inside our country, this workshop is part of a continuing process of consultation between the ANC and organisations from home.

The choice of Maputo as the venue for our deliberations is also significant. We are meeting in a country which has been ravaged by a bandit war, sponsored by the Pretoria regime, in which health facilities have been prime targets. The fact that we are meeting in Mozambique is indicative of the support we enjoy in this country and also of Mozambique's commitment to progressive health policies. We are grateful to the government of the People's Republic of Mozambique for hosting this occasion and equally thank the Frontline States and all our international supporters who have contributed towards this meeting's success.

South Africa in transition

One of the major themes of this conference is "Health in Transition". South Africa has passed the point of no return and stands on the brink of a transition period. What has brought us to this point has not been a change of heart on the part of the regime, but the relentless struggles waged by our people over the years, supported by the international community. It was these struggles which compelled the Pretoria regime to release Comrade Walter Sisulu and other ANC leaders last October. It was these pressures which led to the unbanning of our organisation and the historic release of

Comrade Nelson Mandela in February.

While the ANC has commended Mr de Klerk for the steps he has taken thus far, it is necessary to reiterate that the measures announced in February still fall short of those envisaged as necessary to create a climate conducive to negotiation in the Harare Declaration.

The ANC has, since its inception, been willing to seek a peaceful solution to the conflict in South Africa. What has always been lacking has been a matching commitment from the other side.

The ANC condemns the privatisation of health services

The existing health care system in South Africa is grossly inadequate. Reflecting the essential characteristics of apartheid society in general, the current health system is inequitable and skewed towards providing curative services for the wealthy white minority. The disease pattern in our country mirrors basic socio-economic conditions. The most prevalent diseases among the oppressed majority are the diseases of poverty yet the majority of health care resources are concentrated on combating the diseases of wealth.

As an integral part of the struggle of our people against the inequities of the apartheid system, health workers have become involved in struggling for the establishment of a national health service in South Africa, based on the principles of primary health care and geared towards a programme of health for all by the year 2000. The ANC endorses this goal as the basis of the health policy of a future democratic, non-racial, unitary South Africa. Implementing this objective will, however, be no easy task. A programme to transform the health system in our country will have to be firmly rooted in a clear understanding of the complexities of the present situation and an identification of the realistic options. The state's current policy of making individuals financially responsible for their own health care in a privatised health care system is in flagrant contradiction to the concept of health for all. The ANC unequivocally condemns the regime's programme of privatising health services. We see privatisation as a manoeuvre aimed at limiting the options available to a democratic, non-racial government. By starving the state sector of resources, privatisation policies seek to guarantee that a substantial part of the existing health infrastructure will remain available to provide privileged access to services for a minority with the means to pay. It will be the task of a future democratic government to guarantee health for all. Health in a future democratic, unitary, nonracial and non-sexist South Africa must become a right and not a privilege.

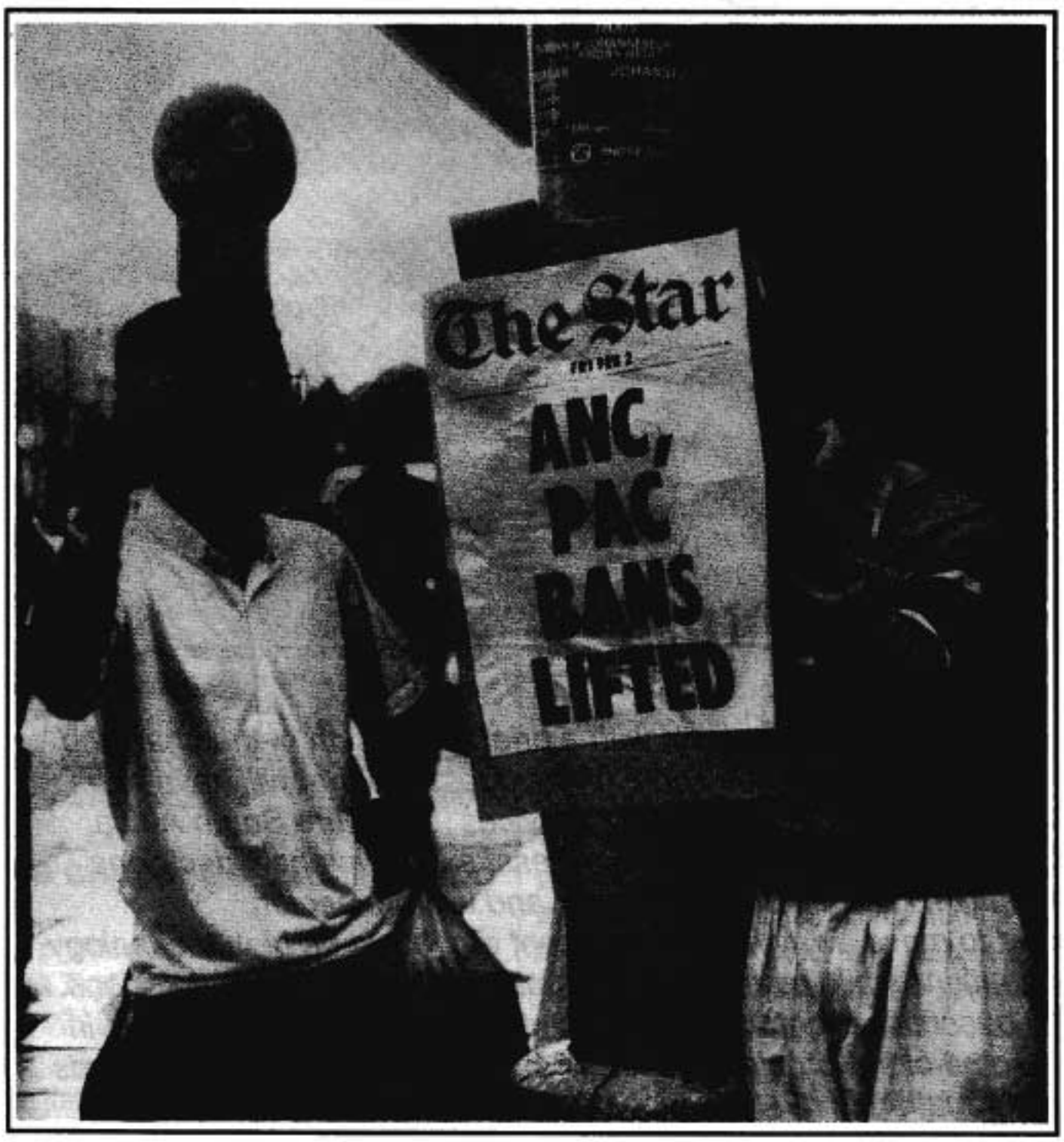
The masses of the people, through their organised communities, must also play a significant role in determining the character of our National Health Service. We do not see the formulation of health policy as the exclusive preserve of the health profession or government officials. All our people must become involved in this process if we are to have truly democratic health system.

Our health policy will also have to be rooted in an understanding of the socio-economic and environmental impact on health. We cannot have a healthy population if our people do not have enough to eat or are forced to subsist in inadequate housing. We need to play our part too in developing awareness of the effects on health of environmentally irresponsible policies.

We also support proposals to establish an essential drug programme, which will ensure that basic drugs are available and that wasteful expenditures in response to commercial pressures are avoided.

ANC concerned about AIDS

The ANC recognises and is deeply concerned by the threat posed by AIDS - a disease which knows no geographical boundaries, class or racial divisions. It is a potential threat to every one of us, but it is a menace which is made worse in our case by aspects of the apartheid system such as migrant labour and the inadequacies of the current health care system, especially for blacks. The ANC hopes that the deliberations of this workshop will result in the drafting of a programme of action on AIDS as a contribution to a national policy on this disease.



Jubilation at the unbanning of political organisations - the fruit of decades of struggle.

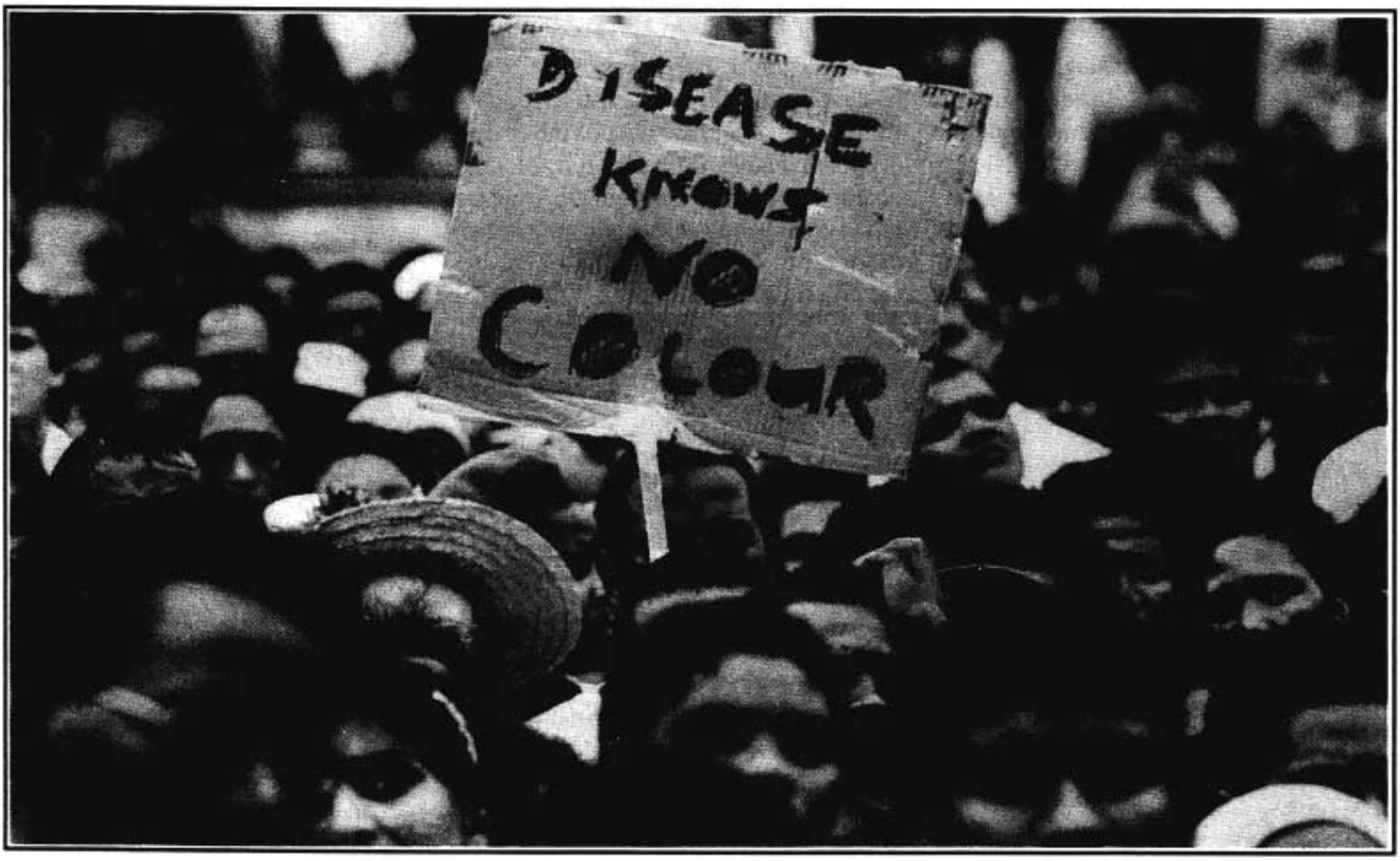
Thanks due to internal organisations

The past decade has seen the emergence of a number of health organisations committed to an alternative democratic health care system in our country. The ANC commends all those who have been involved in this great initiative. Sacrificing the privileges potentially available to health professionals, a growing number of doctors, nurses and other health workers have dedicated themselves to the people's cause. Progressive health workers have been prominent among those who have sacrificed their liberty and even in some cases their lives in the struggle for a non-racial, democratic South Africa. We commend all of the organisations and individuals fighting to transform the health system in our country and look forward to greater unity in action in the future.

May I, finally, on behalf of the National Executive Committee of the ANC wish this conference every success. We look forward to receiving the results of your deliberations and your recommendations. I assure you that the ANC will study them with the seriousness they deserve. ❑

Transforming health and welfare services

Problems and prospects



*This paper by **Leila Patel** and **Cedric de Beer** begins with a brief discussion of the changing political environment and in this context, identifies some of the questions that will have to be answered in the transformation of the health and welfare services in a future South Africa. It highlights the need for equity in service provision and access, explaining how decisions regarding nationalisation will influence the health and welfare sector.*

The authors express the need to move away from the present emphasis on high technology care to more appropriate interventions while recognising the possible costs of such decisions.

The paper raises important questions regarding the concept of community participation in decision making and identifies some of the problems faced with attitudes of personnel towards the transformation of health and welfare sectors.

This conference on health and social services in transition takes place at a time when the entire political scenario in South and Southern Africa has changed dramatically. The unbanning of liberation movements and the possibility of a political settlement through negotiations may be within reach. These changes have brought a renewed urgency to the debate about a post-apartheid society and pose particular challenges for the liberation movements and for health and social welfare workers in particular.

The government has begun to engage the liberation movements around their proposed social policies and programmes for the future. Two issues have become central to this debate:

- The future economy and economic policy measures and their effect on productivity, employment and standards of living.
- Health, education, social welfare and housing policies and programmes aimed at improving black socio-economic conditions. The national budget presented in parliament this year made provision for a 40% increase in allocations to social services. A further R3 billion has since been earmarked for this purpose.

Clearly the government is embarking on an aggressive strategy to challenge the liberation movements in relation to how a post-apartheid society will work. It is preparing to strengthen its hand at the negotiating table and enhance its image at a mass level and in the international community.

How to improve the quality of life in a post-apartheid South Africa has become one of the central political questions. Lessons from Eastern Europe and Nicaragua indicate that if a post-apartheid government cannot improve people's living standards, then the broad support base of the liberation movements can easily be eroded.

This conference is faced with the stark realities of "what is possible given limited resources".

The challenge of unification

If a political settlement through negotiations is possible it can be assumed that we will inherit a fairly intact health and welfare system. To our advantage we will inherit a workable infrastructure which will continue to operate while the process of transformation is taking place. But it is this very apartheid-ridden, fragmented infrastructure which we are trying to change. Thus we have the more difficult task of unifying the health and social services and building a new system of service delivery while at the same time, dismantling the old. We need to set a time frame for this process and carefully explore all the ramifications.

Some principles of social justice

Equally difficult will be the construction of health and welfare services that meet the social goals laid down in the Freedom Charter, the constitutional guidelines of the ANC and demands, resolutions and declarations of democratic organisations. We suggest equity, appropriateness and community participation as a set of principles to guide our critique of the present health and welfare system and future post-apartheid policy makers and planners as they move towards reconstruction.

'In reality we will not be able to do away with dual standards in health and welfare service provision immediately.'

Equity

Racial discrimination in the allocation of resources has been widely documented. If we are to provide health and welfare services to all - that is, in the way these are currently provided to whites - then the allocation of resources for these services would have to increase three fold.

We continually use the comfortable slogan that by dismantling apartheid and through slashing the military budget, we will generate sufficient extra funds to pay for these improvements. But given the needs for housing, job creation and the provision of water and electricity, there is no doubt that the funds will not be available to allocate substantial extra resources to health and welfare. Thus in reality we will not be able to do away with dual standards in health and welfare service provision immediately. Within this reality we will have to devise means to ensure that any additional resources are directed towards those in greatest need: the unemployed, children, women, senior citizens, the disabled, rural communities and so on.

The existence of a large private health sector is a major contributor to inequalities in health care at present. Half of all money spent on health care in South Africa is spent on the private sector which caters for the care of only about 20% of the population. Privatisation remains a cornerstone of the present government's policy, yet, given the millions of unemployed, and the fact that most black people earn a quarter of the income of whites, it is impossible for most people to provide for their own health and welfare needs. Clearly, privatisation coincides with racial differentiation in order to reinforce inequalities in these areas.

The post-apartheid government faces difficult questions with regard to the private sector. Will it be appropriate to nationalise private health services; to take over private hospitals; to force private practitioners into state employ; to nationalise medical aid schemes, pension funds and the various forms of private death and disability insurance that middle class people have stored up for themselves?

A decision that a process of nationalisation is undesirable or impossible will have far reaching implications for how we evolve a system of state social security. It seems inevitable, for the foreseeable future, that the state social security system will be a mixture of contributory (e.g. contributions from employers and workers) and non-contributory (tax funded) benefit systems. This in turn has implications for our capacity to promote equity, as it is likely that existing inequalities such as those between the employed and unemployed, may be reinforced. It is from such inequalities that political opposition to a future democratic government may develop.

Certain inequalities will, however, remain with us for many years. Hospitals and other health care facilities are mostly concentrated in white areas. This is a serious problem where patterns of settlement have been distorted by the Group Areas Act and the homeland system. We will have to address questions such as: should we close the white Johannesburg Hospital and move the medical school to Baragwanath Hospital where it will be

Contrary to popular belief, dismantling apartheid and slashing the military budget will not generate sufficient extra funds to pay for an equitable health and welfare service for all.

able to serve the people of Soweto more effectively? Also, there are other barriers to access to health and welfare services such as language, age, sex and the cultural background of health and welfare workers. Welfare workers, for example, are predominantly white, while the population they serve is generally black.

Creating appropriate services

Our present services are fashioned on outmoded colonial or present first world models of service delivery. This approach is essentially curative and relies on highly trained professionals to render services. Similarly, in the welfare sector, the case work model is the dominant mode of intervention in social problems. This excessive focus on individual disorders has the effect of ignoring and concealing the social causes of illness as well as the causes of social problems that are dealt with by social workers and welfare agencies.

We need to develop new models more appropriate to South African conditions. In health care this means that we must give priority to the provision of comprehensive preventive, promotive and curative primary health care in the communities. In welfare, the importance of preventive interventions means redirecting our focus towards community and social development. Specialist services are obviously still necessary, but specialists should be used to provide support and training for community-based primary services, which must be our priority.

While specialist services are obviously necessary, difficult choices will have to be made in order to generate the funds necessary to spread primary and comprehensive services to all those communities currently deprived of them.

In reality, the implementation of these approaches involves the making of difficult choices. For instance, will we have to close some hospitals or some specialist services such as organ transplant units? Should we leave high technology research to scientists of North America and Western Europe? Should we be shutting down marriage counselling services and move away from labour intensive forms of intervention such as psychotherapy? Such drastic steps will have their own negative consequences but if we do not make these choices, then it is unclear how we will generate the additional funds and extra personnel to spread primary and comprehensive services throughout all those communities which are currently deprived of them.

Making community participation work

Much rhetoric abounds with regard to the concept of community participation in the planning and implementation of health and welfare services. There are a number of obstacles to confront if we are to give life to this crucial principle.

Firstly, technically complex decisions have to be made. Given the lack of familiarity with these issues and the enormous backlog in education, it is not clear how we expect people to participate in making such decisions. Secondly, participation is costly in terms of both money and the participation of personnel in the process of consultation. There are also important questions to answer regarding appropriate structures through which people should participate in the

planning and implementation of health and welfare policies and whether people will have the time or the inclination to participate in such a wide range of structures and forums, eg. education, local civic matters etc.

Also, there is a large voluntary sector of religious and other organisations involved with social services and welfare. Burial societies and stokvels are based right inside the communities. We need to ask how they will be included into the planning and decision-making processes and whether they should receive funds from the state for their services.

The strength of the mass democratic movement has developed models of participation through separate local community and trade union based structures in which grass-roots participation can occur.

However, as these structures tend to be politically aligned, we must ask whether participation would depend on the political affiliation of individuals. This may result in political allegiance becoming the criterion for access to resources which in turn, may result in the emergence of new forms of privilege and consequent elitism.

Failure to address all these questions could lead to token participation and misuse by political factions, bureaucrats and other emerging elites.

Assuring adequate personnel

Winning the support of personnel

A political challenge facing a post-apartheid health and welfare ministry is whether it can win the support of existing health and welfare workers for its new policies and programmes (focused around a primary care, community-based approach within a unitary system).

We must recognise that there are administrators and other personnel who believe that their jobs or status depend on the existing fragmented structure.

Highly skilled and influential people in the private (particularly health) sector will mobilise substantial opposition to attempts to reduce the size of the private sector and to attempts to exercise greater control over the provision of private services. Also, our training institutions and their graduates emphasize specialist and curative skills and tend to regard community-oriented preventive and promotive work as second class, and essentially irrelevant to professionals. In addition, professional jealousy, within and between the professions, results in specialists objecting to lesser qualified workers doing work they think belongs within their empire. Professional groups tend to regard lay workers as constituting a dangerous invasion of their territory.

These workers will either implement or sabotage post-apartheid policies.

Training personnel

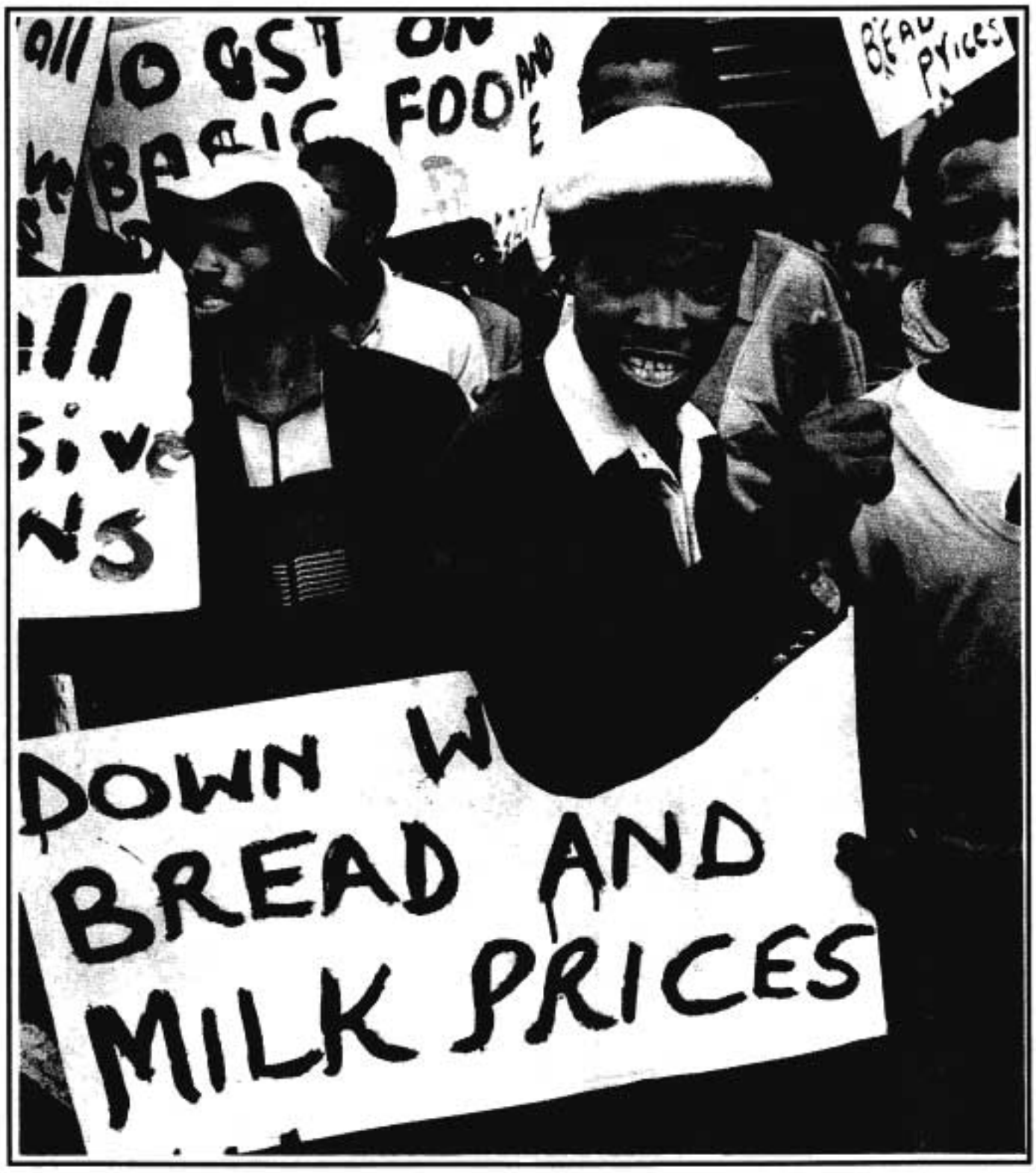
On a technical level, we need to define how many health workers we need and with what level of skill. We will then have to train or retrain large numbers of health and welfare workers with more appropriate skills. Ways of encouraging them to work in underserved areas must be found.

Finally, we will have to find ways to redress the enormous racial imbalance in the numbers of health and welfare service providers. To do away with racial biases in the services we will have to change the current situation where most managers, planners and policy makers are white.

Conclusion

A post-apartheid government will have to make decisions with far reaching implications for the social services in general.

Restructuring will involve the dismantling of apartheid at every level and the development of a unitary system combined with democratising of local, regional and national structures will be paramount. Restructuring must promote equity with regard to racial, class, gender and geographic divisions. ❑



Privatisation remains the cornerstone of the present government's policy, yet given the fact that many South Africans cannot even afford basic foodstuffs, how will they be able to pay for their own health care?

Moving beyond slogans

Transforming welfare in South Africa

***Francie Lund** outlines the principles on which a just welfare policy should be based and argues that four major questions must be addressed in the restructuring and financing of the welfare service in South Africa.*

This article highlights only some aspects of the paper presented by Francie Lund at the Maputo Conference.

Johannesburg 1990 - health and welfare workers march through the streets of the city.

There is broad agreement within the welfare sector in South Africa that the welfare system is racially discriminatory and not properly planned. There is an inadequate pattern of provision: a relatively sophisticated service with good coverage for a few, and a very patchy, undeveloped service for the vast majority of South Africans.

There is broad agreement also that a future welfare policy should embody the following elements:

1. It should be targeted at the most needy individuals and groups.
2. It should have a goal of equitable distribution and allocation of resources.
3. It should lead towards an efficient service delivery system.
4. It should be a visible policy and system, so that its benefits and its drawbacks can be seen and acted upon.
5. It should include citizens' participation in the identification of needs, the formulation of policy, and in the control over services.

There will be an increasing expectation that the domain of social policy will be seen and used as a vehicle for redistribution (van der Berg, 1989) and that resources are now and will in future be limited - that the ability to redistribute depends crucially on having something to redistribute. Even after the enormous defence budget is pared and trimmed, and savings have been made through deracialising bureaucracies and re-incorporating the homelands, it is likely that painful choices will have to be made about the allocation of resources.

With this in mind, there are at least four basic questions which must be addressed if discussions about restructuring and financing of welfare are to take place in any meaningful way.

1. What is the basic package of welfare goods to which people will be entitled?

The welfare sector needs to get beyond the broad statements of "equal care for all", or "enhancing the quality of life". It is time to start considering, in concrete terms, the "non-negotiables" that would be included in a package of basic rights in the welfare domain.

There is a need to develop a theory and practice of primary welfare care, as has been done for primary health care and is being worked towards by Freeman (1989) for mental health care in South Africa.

2. What will be the role of the voluntary welfare sector in a post-apartheid South Africa?

Some of the confusion that clouds discussion about restructuring and financing of welfare stems from the lack of clarity about the difference between ownership, control and financing of welfare services. Any government can involve itself in the welfare field in one or more ways. It can provide a direct service itself; it can subsidise someone else to provide the service; and it can regulate the way in which someone else provides the service. What is important here is that the agency which finances the service is separable from the agency which delivers the service; and it is a matter of socio-political decision-making and arrangement as to how much control over the service the financing agency has. Of overriding importance, furthermore, is that welfare's constituency is by definition the poor and the vulnerable, and that state spending must underlie the welfare services.

The voluntary welfare sector is not operated for profit. Where fees are charged for services rendered, they supplement or top up the sources of financing which come from subsidies and from fund-raising. The advantages of a voluntary welfare sector are to do with its structural location (not necessarily its financing) outside of state welfare bureaucracies. Arguably, this enables welfare organisations to provide a more responsive, flexible and innovative service, which often shows the way that the state should go in moving towards a more comprehensive service.

A disadvantage of the voluntary sector, as it exists at the moment, is that it has not developed as a result of co-ordinated holistic planning. Rather, a predominantly urban-based voluntary welfare sector has developed with much overlapping in the provision of some services, and no provision at all in others. The sector has a bias towards provision for white people, as this is the group which has had the resources to initiate welfare efforts.

The fact that voluntary, private provision has led to such unplanned provision does not in principle stem from the fact that it is voluntary. If the advantages of the voluntary sector outweigh state provision (not financing) in terms of flexibility and responsiveness, and the ability to reach groups and individuals who really need services, then one can envisage a situation where a heavily state-subsidised voluntary sector exists, with the state using the subsidy system to drive more extensive coverage, or more targeted coverage, or both. For example, a mental health organisation could get an increased subsidy if it opens up offices in rural areas (an example of extended coverage), and if it introduces services for non-psychotic mental disorders (targeted coverage).

3. What happens if you impose an equal service on an already unequal system?

It is in the spirit of progressive politics that a future South Africa will be based on the ethic of equal rights. There is an acknowledgement that past imbalances will have to be redressed ("redistribution as retribution"); there seems to be a consensus about some form of national health service and welfare state.

However, there is growing evidence that the British welfare state, which had a strong emphasis on free services, has disproportionately advantaged the middle class as opposed to the working class (Le Grand 1984). This is because a member of the middle class is more likely to be better-informed and know

about what services are on offer and where to find them; is more likely to be able to take time off work to seek those services out; is more likely to be able to use his or her own car or afford the bus-fare to get to the service; is more likely (because more articulate or of the same race or language group) to be able to get past the "gate-keepers" of health care delivery (part of whose informal role and function is to keep clients away from an over-burdened service); and is more likely to demand and get a better or fuller service.

Thus, equal service when imposed on an already unequal society, has tended to favour those who are already more advantaged. It is essential that in South Africa, one of the most unequal societies in the world, ways are explored of positively skewing the provision of services towards those who need it most.

4. What will be the role of the social security system?

The extent of the present social security system (pensions and grants to the elderly, disabled people, and children) is often underestimated. Though pensions and grants are racially discriminatory and difficult to get, they represent a significant part of state social spending - approximately R3,6 billion for 1990, of which about R2 billion went to black (African) people in rural and urban areas. It is quite clear that in black rural areas, pensions and grants are viewed as a household asset: the amount does not all remain with the individual recipient.

The dependency on pensions in rural areas is so strong because it is the only service which effectively reaches into rural households, and has to meet a wide range of needs. In this context, the continuation of the pension system (but operating at parity) has to be seen as a non-negotiable in a future welfare system. If pensions are seen as too heavy a burden on the government budget, the social security system needs to be viewed holistically, with education, health, child nutrition, unemployment insurance and pensions all being placed on the same table for consideration of alternative policies.

Equal service when imposed on an already unequal society, tends to favour those more advantaged and articulate. In South Africa, one the the most unequal societies in the world, we need to explore ways of positively skewing the provision of services towards those who need it most.

Present priorities

As for the present, we need to use every possible opportunity to make plain to the government, the private sector, the public, and those who control the social work profession that the welfare air is full of mixed and contradictory messages.

- The Council for Social Workers appears to spend an excessive amount of time and money on controlling and regulating private practising social workers and on the registration of social work students. It does not appear to provide any vision of welfare in a post-apartheid setting, nor play a sympathetic, supportive and facilitating role which would allow social workers to respond more appropriately to real community needs.
- The government allows the setting up of casinos and gambling in "independent states", but will not allow a lottery which might form the basis for a significant attack on poverty and unemployment, using the argument that this is a form of gambling.
- Welfare workers are told to get more programme funding from the private sector, but the latter is constrained by donations to welfare not being tax-deductable.
- Welfare workers are told to move more towards community care, but are not given the means to do so, for example by the provision of grants for lay home carers of the elderly.

The welfare movement has been assured by Pretoria that welfare is already privatised and that privatisation will not go further. Even if this were true, it misses the point - privatisation in other sectors such as health and housing will create further class divisions, leaving many more people in poverty. These people will be told to "go to the welfare" with their problems. We need to monitor and document how this is happening, and add our voices to those in other sectors who are opposing the government's privatisation project.

Future policy

These questions deal with the situation as it is at present. Future policy thinking will need to take into account three factors which will have a significant impact on what the future tasks of welfare will be:

- If the present violence in Natal is indicative of the kind of process which will be gone through before a settlement is reached, then social workers for a long time to come are going to be dealing with massive social dislocation, affecting whole communities.
- The spread of the AIDS epidemic will present the welfare sector with formidable challenges, in terms particularly of the care of orphaned children, and systems of community-based counselling.
- The organised labour movement is successfully drawing more welfare benefits into their wage negotiations. The more welfare is linked to the place of employment, the more the state can withdraw with stealth from its commitments to its citizens. The implications of this for a growing gap between the relatively better off people in (urban) employment, and those without access to formal employment are worrying, and will directly impact on social service work. ❑

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Building a welfare state

Conceptual framework and practical steps

By Nombulelo Hlatshwayo, ANC

The basic components of a welfare state are full employment, a range of universal or comprehensive social services to cover basic needs such as income, security, medical care, education and housing and a set of social assistance services (e.g. family allowances). However, the specific form of the welfare state differs from one national socio-political context to another. For instance, the traditional British welfare state differs from the Swedish one.

The concept of a welfare state emerged in capitalist countries during the post-World War II period as a result of state intervention to protect the working class from the downward spiral of capitalist recession. Under socialism, social welfare is an integral part of the socialist system and centres around the concept of universal services extensively financed by the state.

Welfare as a political tool

In South Africa, a welfare state for whites has been established. The National Party came to power in 1948 as a result of its support base of white workers and so it has to continue securing its support through both extensive social expenditure and through large scale employment in the civil service. Welfare state policies and programmes have protected white workers from the negative effects of the cyclical dynamics of the market economy.

For blacks, there is a residual concept, which means that social welfare services come to play only when there is some breakdown, when normal needs meeting mechanisms of the individual or family break down or when the market economy is unable to meet the needs of vulnerable groups. This kind of service punishes the person for not being able to cope and, due to stringent eligibility requirements, excludes the majority of the people from its benefits. It is clear that social welfare meets an important political function in that it reinforces racial domination. It therefore plays an important role in the increasing impoverishment of the black majority. This is not the type of welfare system we envisage for a democratic South Africa.

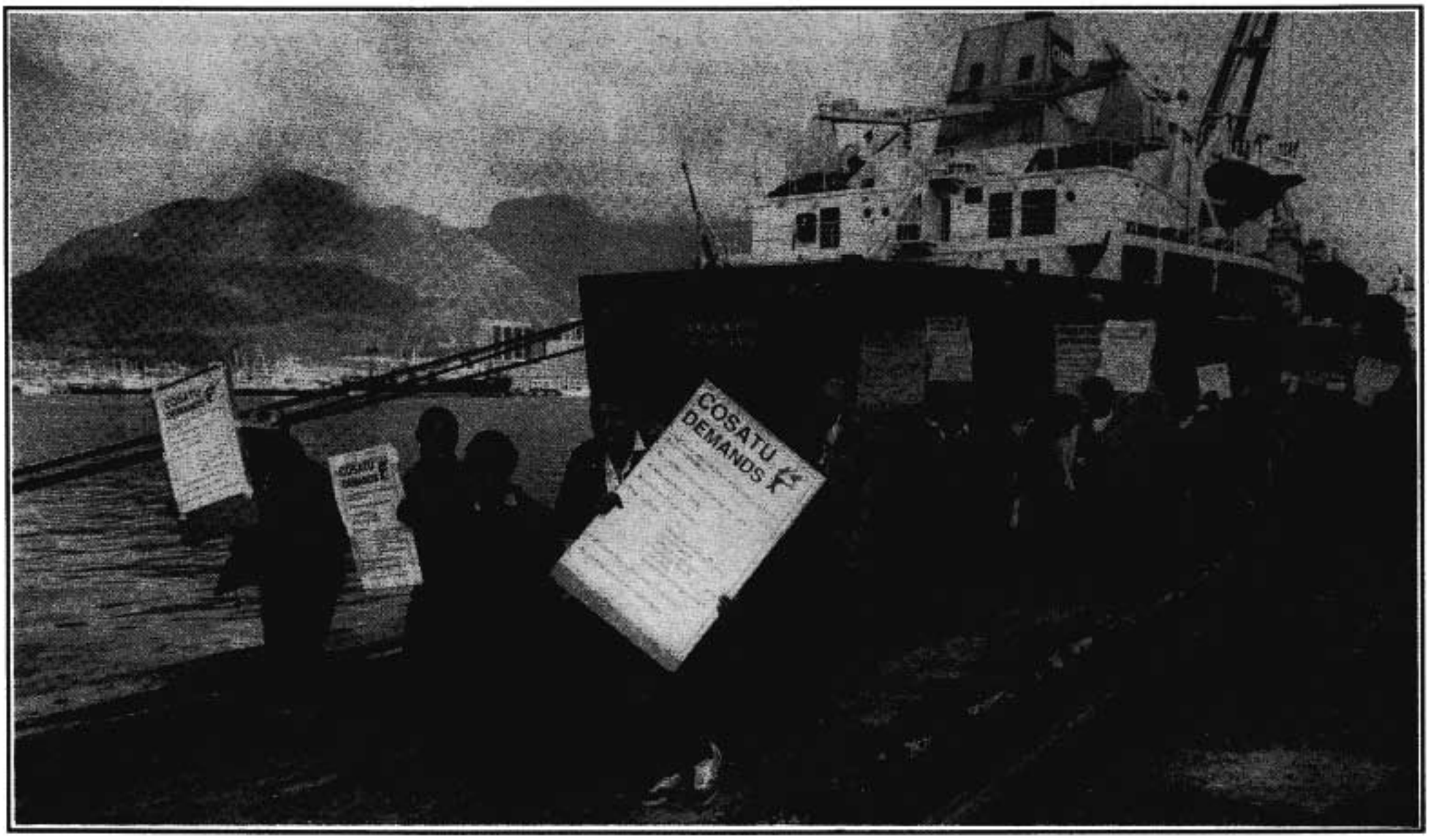
Vision for a post-apartheid society

According to Leila Patel, a South African social worker, social welfare refers broadly to the need for social services to promote physical, social and emotional well-being in a society. Furthermore, the approach adopted for the purpose of this paper is that the disciplines of health, education and welfare are integral to the social reproduction of a society. Each of these disciplines has a specialised knowledge base and practice skills. This is the most suitable definition of social welfare in our situation.

Mass involvement

The Freedom Charter and the ANC's Constitutional Guidelines set the basis for a welfare state in a post-apartheid South Africa. The people's government will intervene in the economy and in the provision of social security for the people. It will institute a national health service and introduce free and compulsory education for all.

It becomes clear that a people's welfare system can only be established if all the democratic forces engage themselves in all forms of struggle. Our central task in this case is to dismantle the racist welfare system. Fortunately many welfare organisations are moving in this direction, and we need to win them and others over to our side. In the past, social



Unions' programmes and policies are rooted in mass participation. Health and welfare organisations can learn much from the strength of the organised working class.

workers were not addressing themselves to the real causes of the people's problems and suffering. Progressive organisations have ignored social welfare organisations because their services have largely been geared towards the alleviation of the conditions of vulnerable groups and, to all extents and purposes, served to cushion and perpetuate the evil system, thus relegating the affected to beggars for services they deserve as their right.

Social welfare on the political agenda

It has been in response to the declining socio-economic conditions of our people that social welfare issues have begun to receive increasing prominence among progressive organisations. The mass democratic movement and the trade unions are taking up campaigns which have a direct bearing on how the needs of people should be met. Their programmes and policies are rooted in mass participation and are geared towards the mobilisation of the working class to demand services, facilities and benefits. If such a tradition is strengthened and deepened, a genuinely democratic people's welfare system would emerge in the future. In this future system, people at grassroots level would be able to defend their rights and interests.

It should be noted that these issues have not been taken up because organisations wanted to meet a welfare need as a primary concern. Rather, they have used these issues as a vehicle to mobilise, organise and educate people against an unjust system. Therefore, the social services and programmes of progressive organisations potentially constitute a framework for evolving social welfare policies and programmes in a post-apartheid South Africa. This shows very clearly that social welfare needs to be placed on the agenda of the democratic movement. The MDM should begin to explore more consciously how their programmes and campaigns could include greater social welfare content, as the need for social welfare in our society arises from the destructive effects of capitalism and apartheid.

Within the ranks of our movement, the ANC, social welfare has been seen merely as material and logistical support for the general membership and its other vital aspects have been ignored. We in the ANC have not only grown in strength inside the country, but we have also grown in numbers out in exile. We are a community and naturally have social problems. The ANC is a product of South Africa and, as a result, carries with it problems which are a product of the system from which we have come. A social welfare committee has been formed to address our social problems. The main tasks of this committee are to design social welfare programmes and services consistent with our organisation's overall policy, and to apply intervention methods which support these policies.

This committee also has the task of developing a theoretical conceptual framework of social work practice in a non-racial, united and democratic South Africa. The Mass Democratic Movement, the trade union movement, welfare organisations and all patriots, together with the African National Congress must work towards the establishment of an alternative welfare system which reflects the revolutionary principles of our struggle!

Amandla! All power to the people! ❑

Restructuring social services in South Africa

This article by Anne Letsebe and Jackie Loffell highlights some key areas to be addressed in the process of restructuring the social services in South Africa. It does not offer ready solutions to the many dilemmas which arise, but identifies some possible strategies in order to focus discussion around the building of a human service system which has maximum grassroots support and makes participation a reality.

Vision and value base

For the purposes of this paper, social welfare refers broadly to social services, social security, social facilities and social policies to promote physical, social and emotional well-being in society.

Social welfare in South Africa needs to be committed to a new vision which promotes social justice, responds to contemporary social realities and holds a vision for change.

In a new South Africa, policies of national development should reflect the central importance of welfare.

Welfare should become an instrument for nation building (for example through initiatives such as family services) and there should be a redistribution of resources to and within the welfare sector. This conception of welfare involves an important shift in thinking - welfare has in the past featured low in public consciousness and the priorities of policy makers.

Some structural issues to be addressed

A Centralisation vs regionalisation

The present system combines some of the worst features of over-centralisation with some serious drawbacks of regionalisation. Authority has been firmly vested in Pretoria as regards major policy decisions and the allocation of funds, and local initiative has been severely hampered as a result. On the other hand, delegation of authority to provincial and homeland structures has led to wastage, fragmentation and inefficiency. Accountability to the general population has been minimal. The system did not evolve out of widespread and open consultation between government and all sectors of the welfare community. The answer seems to be in some kind of middle way, drawing from the potential benefits and avoiding the worst disadvantages of each.

In a system in which the best possible balance is achieved between centralisation and regionalisation, a strong welfare structure at central government level could take responsibility for distributing human service resources equally through the country, and ensuring that key policies addressing agreed priorities are implemented nationally. These might include issues such as pre-school educare for children, anti-poverty programmes and affirmative action for the disabled.

Regional offices could be accountable to central government as well as to local constituencies for their progress, and flexibility and initiative should be encouraged.

B. Fragmentation

Fragmentation in the health and welfare services is legion. In welfare the structure is divided into three racial "own

Principles underlying social welfare policy

*** People are the wealth of a country. They have the capacity to contribute to their own development and to the development of the nation. The government will actively facilitate this development at the local, regional and national levels.**

*** Government will create a new infrastructure that will enable individuals to take maximum responsibility both for their own well-being and the well-being of their fellow citizens.**

*** The family is a natural and fundamental unit of society, and government will ensure circumstances in which secure and fulfilling family life will be protected.**

*** All citizens, irrespective of race, gender, religion, political affiliation or disability will have equal access to human welfare services. In the allocation of scarce resources, the sole criterion will be human need.**

*** The needs of those who are disabled or in any way disadvantaged will be specifically addressed through affirmative action.**

ARGUMENTS FOR A SEPARATE MINISTRY OF SOCIAL WELFARE

- Budgetary allocations: historically physical health care has received more financial resources than social services.
- Differences in orientation: While medical and social service disciplines are closely related fields, they involve separate bodies of theory and expertise which remain distinct from one another despite areas of overlap.

  Also, while health workers and the social services have vital roles to play in areas such as housing, employment, education and social development, their contributions will be different.
- Status differentials: experience has shown that where there has been a merging of health and welfare structures inside South Africa, these have typically been dominated by health personnel who (particularly doctors) are attributed particular status in a community. As such, the structures have come to focus on physical health at the expense of other important aspects of the overall well-being of people.
- A separate ministry of social welfare would focus on specific problems of social welfare which have been overlooked in joint ministries.

ARGUMENTS FOR A SINGLE MINISTRY OF HEALTH AND WELFARE

- Decreasing fragmentation;
- Maximising the use of available facilities for meeting a wide range of human needs;
- Better co-ordination;
- Cost effectiveness.

affairs'' departments and one Department of Development Planning which deals with 'African interest'. These are further broken down into four provinces embracing parallel structures of local welfare committees, regional welfare boards, and national advisory councils. All these divisions each have their own fields of service and working committees, leading to even more duplication. In order to prevent conflict, there is a ''common affairs'' South African Welfare Council. There is a National Welfare Policy Council, composed of ministers responsible for welfare, and an Interdepartmental Consultative Committee on Social Welfare Matters, composed of state officials.

This situation is compounded by the presence of the private sector which is particularly fragmented within itself. There is also fragmentation along religious and cultural lines.

The private welfare sector is poorly co-ordinated and does not, on the whole, engage in effective prioritising and strategic planning of its own. In addition, private organisations, in order to survive, are frequently engaged in expensive and highly competitive fund-raising activities on a very individualistic basis.

The division of responsibilities between the state and the private sector requires careful reappraisal.

Voluntary organisations should be encouraged to provide services which, as far as possible, do not simply duplicate those of others, but rather help to make up the total service network.

It is in the interests of all that the private welfare sector be well co-ordinated and engage in co-operative planning and the setting of overall joint priorities.

C. Relationship between health and social services

Given the inextricable relationship between the social, emotional and physical well-being of a person, a critical challenge facing us at this stage is how we structure the health and social services in a way that will not undermine either the physical and psychosocial aspects of those using the services.

Various alternatives to structuring the health and social service delivery system need to be examined. Options include:
- a unitary ministry of health and social welfare;
- separate ministries of health and social welfare;
- a ministry of health and social welfare with separate departments of health and social welfare.

(The arguments for and against these options are summarised in the adjacent box.)

There are certainly areas of overlap in the relationship between primary health care and community social work, but the most significant constraint to the integration of the disciplines is that the social welfare and health systems are structured in a way which undermines linkage between the two. Professional elitism flows from this, creating another barrier to co-operation (L.Patel).

It seems unlikely at this stage, that the full contribution which the health and welfare sectors have to make can be kept in the proper balance within one system. This situation should, however, be re-evaluated periodically. Meanwhile, co-operation at every level is critically important. The entire field of primary health care, for example, with its critical role in family life and national development, calls for intensive pooling of skills and resources between health and social service practitioners. This pooling could be extended to a variety of potential multi-service settings - e.g. advice centres might offer personal and family counselling and basic health information along with legal advice.

D. Inequalities and maldistribution of services

Racial and rural-urban inequalities are the most obvious issues to be addressed in this regard. A starting point to overcoming racial inequalities would be to make any form of discrimination based on race illegal for any state or state-subsidised organisation. (The question as to whether other restrictions on access to service, such as religion, should be treated likewise - creating a requirement that no taxpayer's money be allocated to

services which restrict access on the basis of any sectarian consideration - is a more complex issue requiring further discussion.)

Opening services is not, however, simply a matter of dropping racial clauses from constitutions. It also has to do with making services accessible and acceptable to, and effective for, a variety of people. Training and recruitment programmes to equip staff to work across language and cultural boundaries would be essential to such a process.

More open systems, involving resource persons who can be freely available to all, team consultation and democratic decision-making, will be required. Participation in agency planning and policy-making by those using the service will be critical in enabling programmes to make whatever adjustments are necessary to ensure their relevance to the needs of new consumers.

State leadership with community participation will be required in identifying the rural and urban areas in which services are lacking. Resources should be injected into such areas as far as possible and the government could give preference (in various forms of benefits) to voluntary initiatives in deprived areas.

Medical and social service graduates could be required to give services in rural areas in repayment of study loans, or such work could be instituted as a kind of "national service" for one to two years. Church and service organisations and perhaps international aid schemes could help to develop the infrastructure.

E. Integration of curative and preventive services

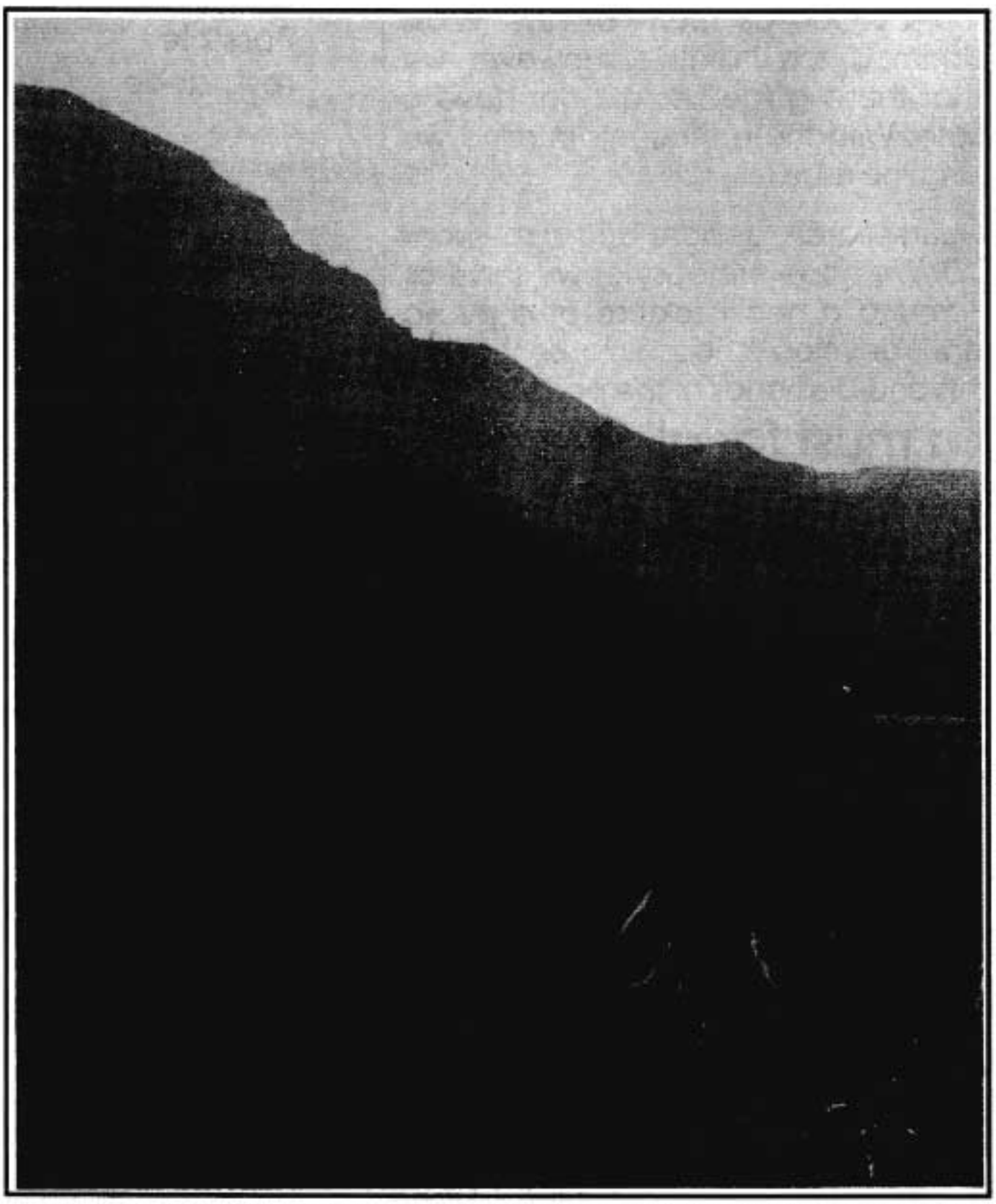
As we know, the present system has been heavily loaded towards curative services for individuals with social problems, with a bias towards the needs of white South Africans. Also, until recently, state financing of social work has been almost exclusively for poor quality curative social services, particularly where black people are concerned.

Far greater priority should be given to the primary prevention of social problems. At the same time one would not wish to lose the benefits of the high levels of skills which have been developed in therapeutic social services.

It is important that the decisions as to where the emphasis will lie be democratically reached. It is crucial to obtain mass participation in the setting of the necessary priorities and the making of the crucial choices involved. Service consumers themselves form a vital constituency to be consulted in this regard.

Private welfare organisations could be encouraged to emphasize prevention and development by being required to allocate a certain percentage of their budgets to such work in order to qualify for subsidy.

Examples of preventive programmes that exist and could be expanded on are: family life programmes; parent effectiveness training programmes; single parent support groups; pre-marital counselling, child minder programmes for the children under their care; after school care programmes; homework centres; holiday programmes and youth volunteer programmes. Motivational programmes including career guidance and counselling, discussion forums.



The neglect faced by rural areas must be addressed in the redistribution of welfare

Practical suggestions for implementation

Given the present reality and a vision of a future welfare system as outlined in this article, the following are some of the issues we can and must address in order to make this vision a reality.

- Putting social welfare firmly on the agenda of progressive organisations.
- Developing a democratic social welfare movement: mobilising the welfare community towards the development of democratic welfare policies, responsive to needs; and create an awareness of the realities of poverty.
- Confronting apartheid in welfare:

- Engaging social welfare personnel in a process of self transformation through programmes that could help them confront their own prejudices and thus pav-

ing the way to confronting apartheid in formal welfare structures.
- Supporting formal welfare agency heads who are fighting apartheid in welfare, for example, promoting on merit rather than on the basis of colour and monitoring agencies that continue to discriminate on racial grounds and recommending to government that subsidies be withheld from agencies that continue such discrimination.
- Providing a time frame over which certain changes should be implemented by agencies.
- Providing incentives: supporting non-governmental agencies by subsidising self-help programmes initiated by the non-governmental organisations.

● Confronting professional elitism:
- Democratising formal welfare organisations by encouraging community participation in the development and control of programmes.
- Engaging in education programmes to empower service users and to teach them about their rights in every field of practice.
- Training other categories of helpers for specific tasks that do not require highly trained personnel.

● Preparing for the reception and integration of returning exiles.

● Networking: establishing inter-disciplinary helping networks to work with community groups in identifying priorities for social welfare and designing programmes.

● Carrying forward the debate on the structure of health and social welfare.

● Addressing the urban bias towards employment by social workers and other health personnel.

● Student training:
- Reviewing training content in curricula to enable social workers to respond appropriately to practice needs. Emphasising holistic health care and social service delivery.
- Encouraging combined training of students in certain areas, e.g. human relations and interpersonal skills.
- Joint placements for students in community projects.

● Research into specific welfare issues needs to be a priority area for health and social services.

Possible resistance

Because social welfare is largely a response to working class demands, we will experience resistance from capital and the government. Professional attitudes to change and the problems created by expectations as a result of redistribution of resources will also have to be dealt with. ❑

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The provision of hospitals and clinics in South Africa

Some steps to redress the problems

A number of papers have demonstrated the harmful effect that apartheid has on the mental and physical well-being of an individual and society as a whole. The racial inequalities between the black and white, as well as urban and rural, distribution of hospital beds and clinics is also well known.

This paper by Kamy Chetty focuses on the distribution of fixed health facilities (hospitals and "stationary" clinics) in South Africa for the different levels of health care and analyses some of the problems with the present distribution. Steps that can be taken to redress the problems are suggested.

Distribution of facilities for primary, secondary and tertiary care levels

The South African government often argues that health care delivery for blacks in South Africa is better than other countries in East Asia and Africa, by comparing the total of all available hospital beds. A more coherent analysis of the present health care delivery system is provided by assessing the distribution of facilities according to the type of care that is delivered at primary, secondary and tertiary care levels. (Figure 1)

1. The Primary Care level - embraces all general health practice services offered to the population at the point of entry into the system. This includes health workers based in communities, clinics and health centres as well as the general practitioner. This paper will concentrate on fixed clinics and health centres.

2. The Secondary Care level - comprises the more specialised services to which people are referred by the Primary Care services.

These are the hospitals which provide general medical or surgical care, and institutions which cater for specific categories of patients. In this paper, this level has been sub-divided into:

a) general hospitals which provide general medical and/or surgical care;

b) special hospitals which provide long term care for psychiatric or TB patients, and maternity, nursing or geriatric hospitals and/or homes.

3. The Tertiary Care level - includes highly specialised services not normally found at the secondary level. It includes the referral hospitals, highly specialised units and academic teaching hospitals.

The pyramid approach (figure 1) suggests that most of the facilities should be focused at the primary care level with least emphasis at the tertiary level in order to deliver appropriate health care.

Figure 2 illustrates the distribution of hospital beds in the metropolitan areas in the provinces, for the tertiary and secondary (shown as general and special) levels. The graph shows that most of the care in metropolitan areas is delivered by tertiary care hospitals, and that a disproportionately low number of hospital beds provide general care. Further analysis shows that of the hospitals that provide general care in these areas, a large proportion are in the private sector and are "private for profit". This implies that they are mainly accessible to private fee paying and medical aid patients. The following table indicates the percentage of these beds.

Area	% Private for profit
Cape	65
Natal	38
Orange Free State	26
Transvaal	26

Figure 3 shows the distribution of beds at the tertiary and secondary levels in the homelands. This illustrates that greater emphasis is placed on general beds but there still exists a disproportionately high number of tertiary beds in Bophuthatswana, Kwazulu and QwaQwa.

Figures 4 and 5 illustrate the distribution of clinics in the homelands and provinces. These indicate that, with the exception of Venda and Ciskei, there is also a poor distribution of clinics at both provincial and homeland level. The WHO recommendation is 10 000 people per clinic.

The above analysis shows:

1. A bias towards tertiary beds in the provinces.
2. A poor distribution of facilities at the primary care level.

What are the solutions?

Immediate removal of racial segregation at all facilities within provinces will only partially redress the problem of racial inequality.

However, dramatic improvement in the number of beds for the homelands and for blacks within provinces will result if the fragmentation that is created by the homelands system is abolished. This will be achieved through incorporating homelands into the geographical area of the provinces, (i.e. Ciskei and Transkei into the Cape, Kwazulu into Natal, QwaQwa into OFS and the rest of the homelands into Transvaal).

The following tables describe the consequences in terms of hospital beds per thousand population and population size per clinic in each of the provinces.

Despite the improvement after desegregation and the incorporation of the homelands, there still remains a deficiency of clinics at primary care level for most of the country.

Analysis of total numbers alone, however, is insufficient as there are many other factors that affect equity in the provision of health care. Three of these factors are financial access, geographical access and socio-economic access.

Area	Number of beds per 1000 population
Cape	4.8
Natal	4.5
Orange Free State	3.4
Transvaal	4.3

Area	Population per clinic
Cape	11 015
Natal	21 878
Orange Free State	17 958
Transvaal	19 133

1. Financial access

As has been shown, a large proportion of the general hospitals in the metropolitan areas are private, fee for service institutions which are mainly accessible to the majority of whites and a minority of blacks (i.e. those on medical aids). Blacks in the metropolitan areas therefore are heavily reliant on tertiary care institutions for general medical care. This is not cost effective for the health system, as tertiary beds are more expensive than general beds.

The questions this conference needs to address are:

1. Should we build more general hospitals within the public sector, or should the tertiary care hospitals be converted to general care hospitals?
2. Should the private hospitals be made more accessible and if so, how should this be done? For example, do they remain within the private sector, which means the number of consumers within this sector must be increased; should these hospitals become publically owned; or should other options be pursued (e.g. National Insurance Schemes)?

If planning for additional hospitals, the need for primary care level facilities, for referral from these institutions and the ability to equip and provide human resources for them, must be taken into account.

An appropriate balance needs to be sought between different levels of health care. Creating additional hospitals without improving referrals will disproportionately increase the benefit to the urban population.

2. Geographical access

Desegregating all hospitals does not lead to immediate accessibility. Access depends on the location of the facilities, the distance people have to travel, and the availability of transport and communication. In planning for the future, these factors must be taken into account and appropriate solutions found.

3. Socio-economic access

Equity is a social phenomenon and need is based on socio-economic factors. Health and health care delivery therefore cannot be seen in isolation. Social factors such as housing, education, sanitation and an individual's right to an economically viable life is the basic underlying tenet to equity.

Conclusion

This brief analysis shows that enough hospital beds can be made available through redistribution for a future South Africa. However, a micro analysis at regional and sub regional levels will have to be carried out in order to assess the facilities available for the different levels of health care. Fundamental to such an analysis is the question of access to health care facilities. Other factors such as the provision of other facilities (general practitioners, community health workers, and mobile clinics) must be taken into account.

In future planning resources need to be deployed according to population needs and resources available. It is appropriate to concentrate on the primary care level as this will create the conditions for an equitable health system. In this way the imbalances within the present system will start to be redressed. ❑

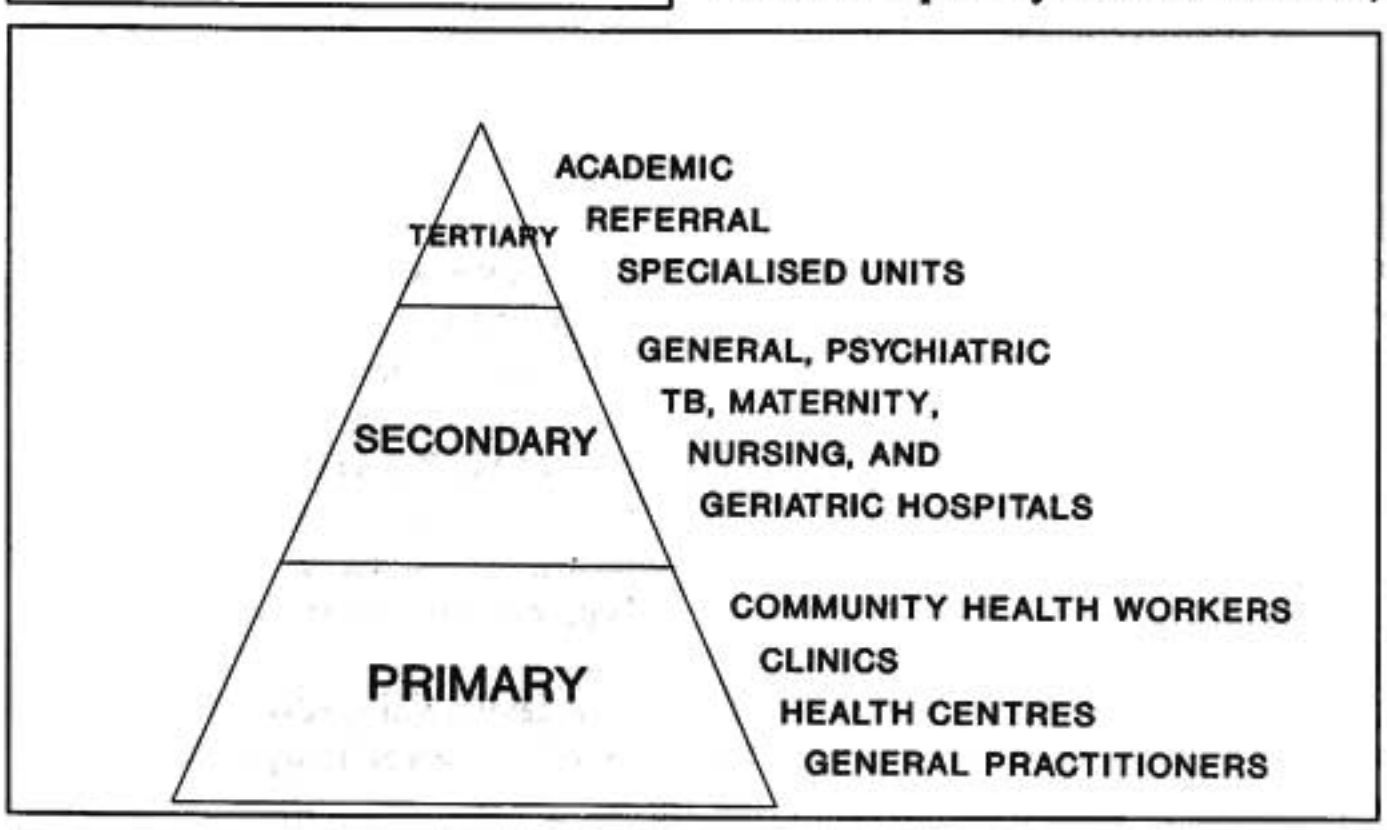


Figure 1. The health pyramid

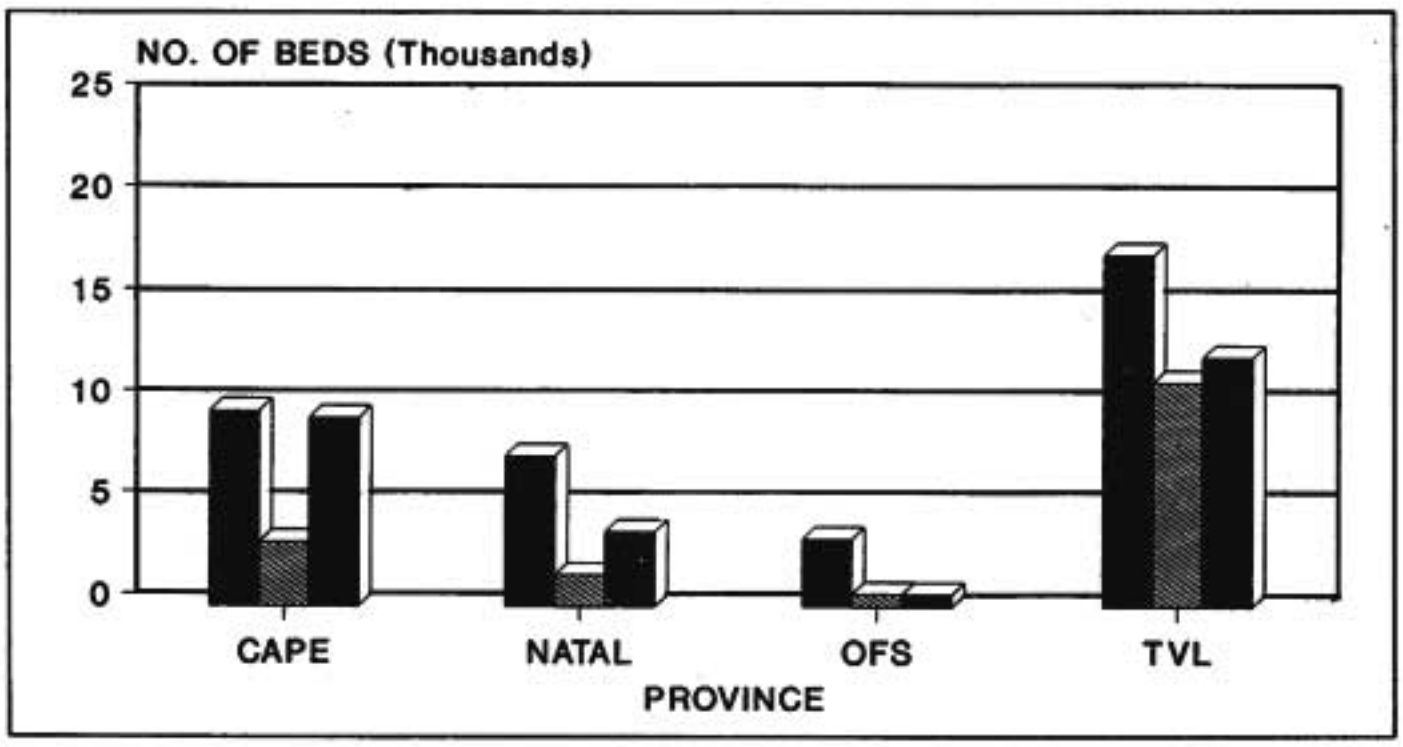


Figure 2
Distribution of beds
Tertiary / secondary level
Metropolitan areas

TERTIARY
GENERAL
SPECIAL

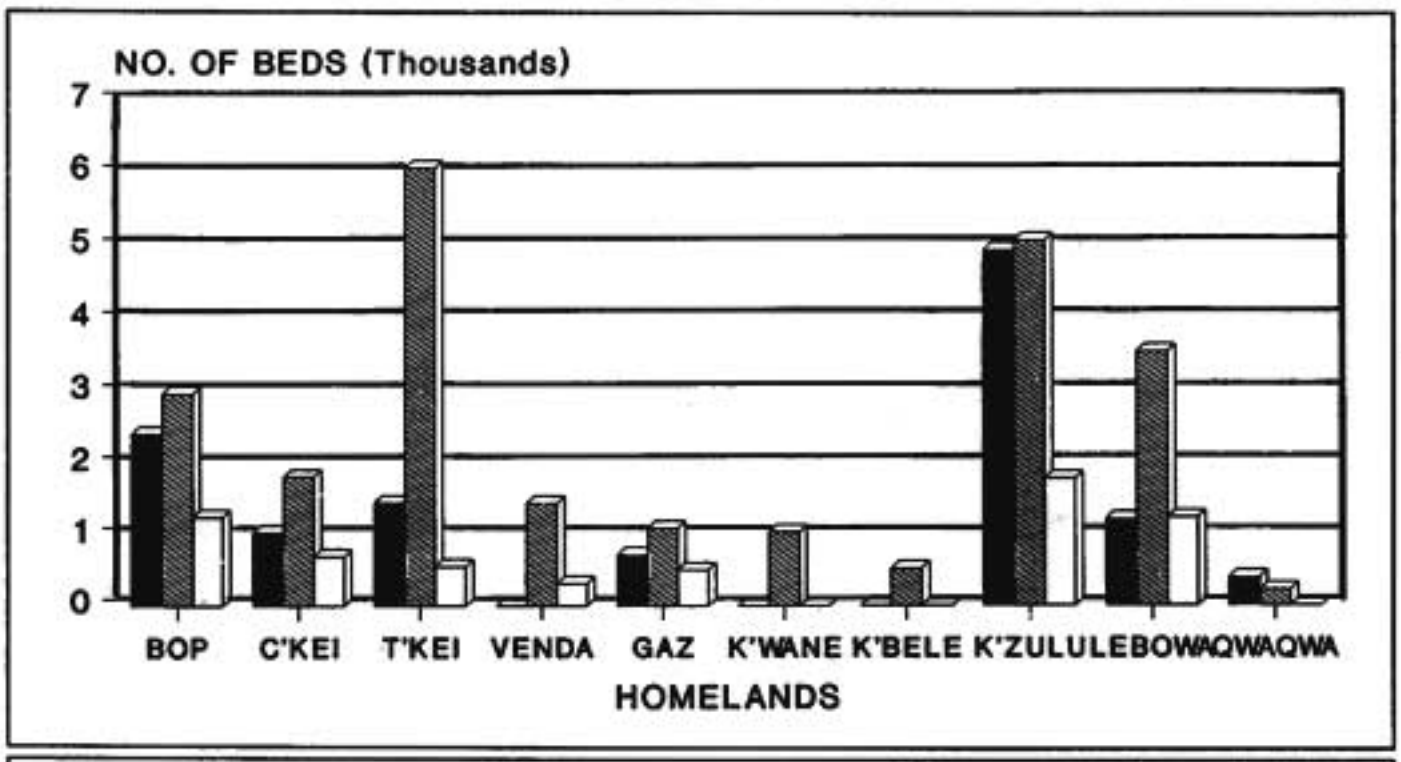


Figure 3
- Distribution of beds
Tertiary / secondary level
Homelands

TERTIARY
GENERAL
SPECIAL

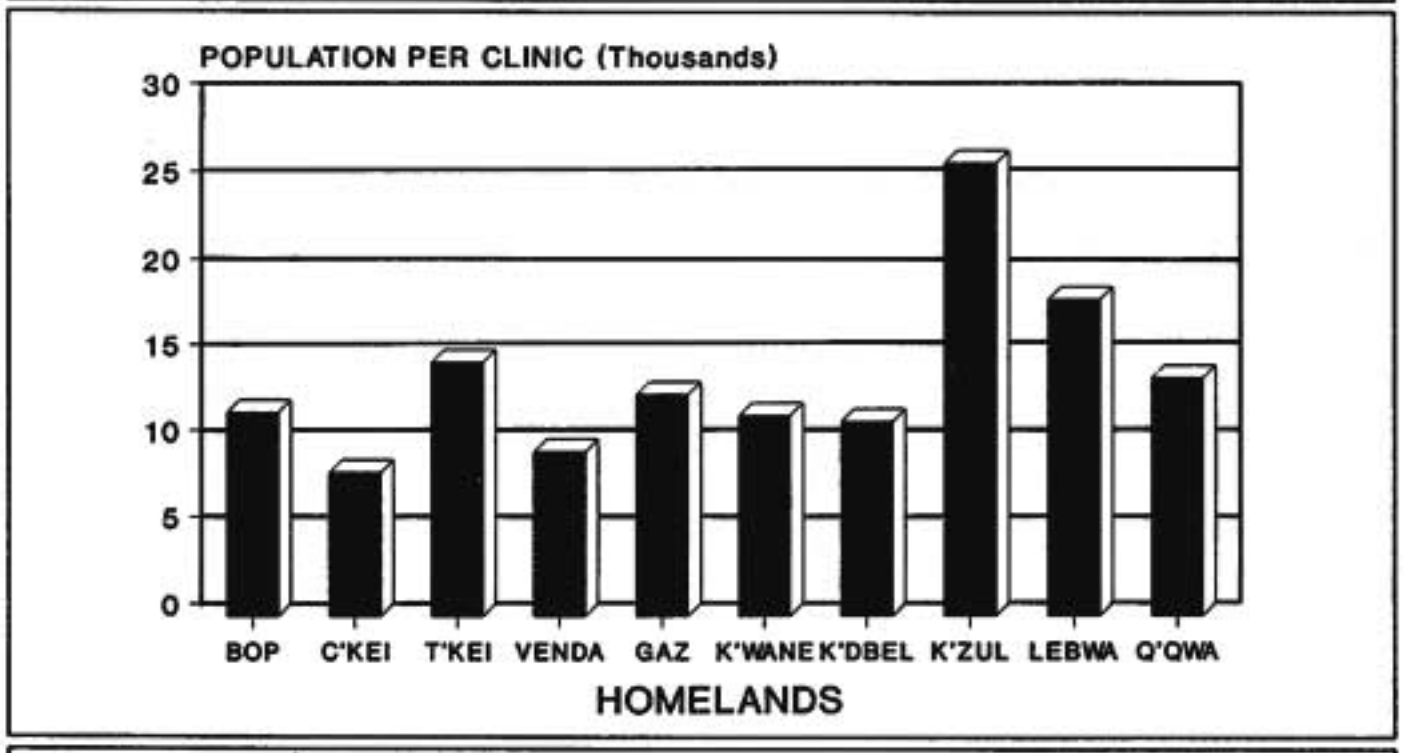


Figure 4
Primary level
Distribution of clinics
Homelands

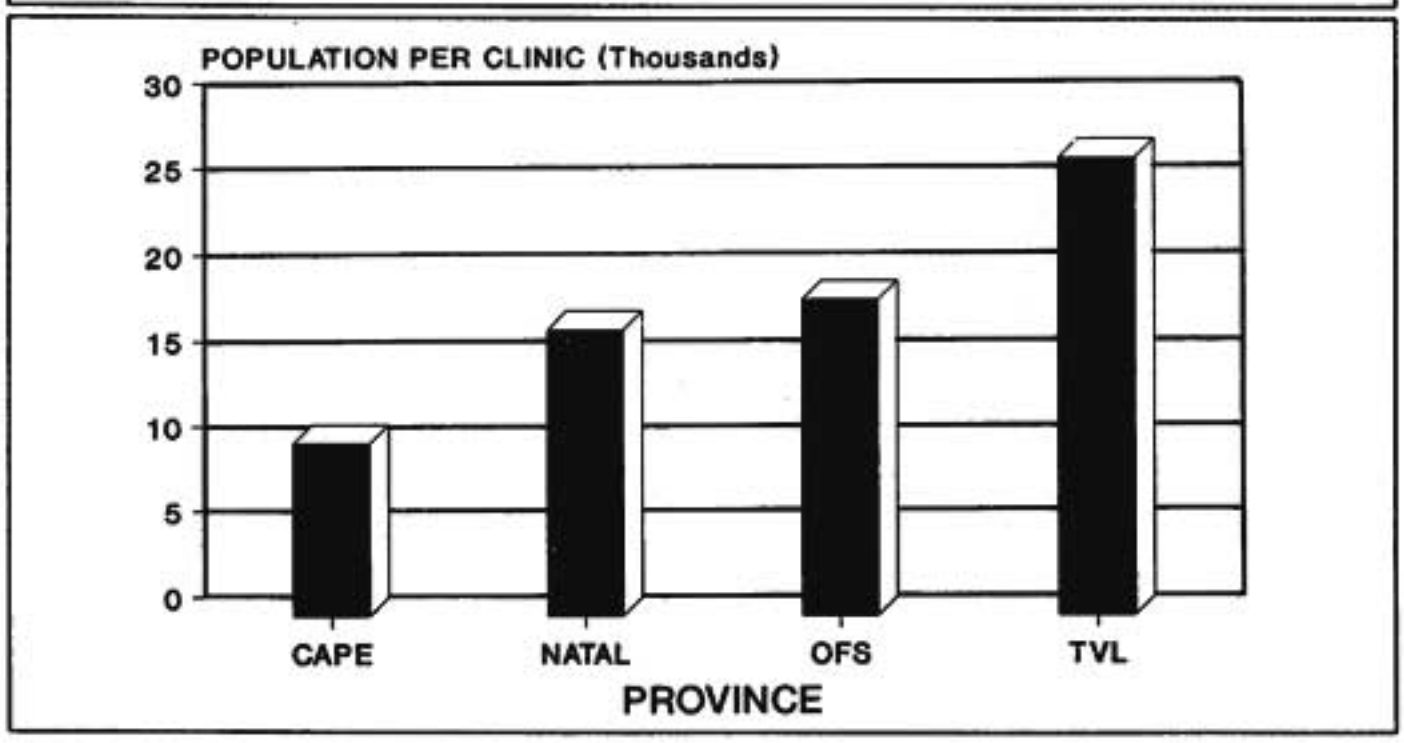


Figure 5
Primary level
Distribution of clinics
Provinces

Towards a new health policy for South Africa

In this article Professor H.M. Coovadia suggests immediate steps that could be taken to formulate a policy for the restructuring of the health care system in South Africa. The establishment of various commissions to achieve this is suggested. These would operate under the guidance of the principles included in this article.

I. Building unity

Apartheid health policies have been an appalling disaster with consequences which will extend well into the next century. These effects have been extensively documented and are referred to in this presentation only in the most general terms in order to substantiate the changes proposed.

The process of constructing a National Health Policy is an ideal opportunity for building unity in the sphere of social services. The issues to be discussed are less open to wide ideological differences and can therefore serve as a focus of bringing people together rather than dividing them further.

The range of organisations to be involved in the construction of a national health policy can be wide and may even broaden out to the margins of state institutions. For example one can consider including: ANC, PAC, AZAPO, COSATU, NAMDA, PPHC, SAHWCO, OASSSA, SABSWA, SANA, IMA, MASA, universities/nursing colleges/ health sciences, upper reaches of existing health bureaucracies, a national registrars' body, an Academy of Family Practice, etc.

II. Principles of reconstruction

The broad principles governing reconstruction of health services should address the major contradictions within this sector:

1. Equity - there must be fairness in availability and accessibility of health services. Ability to pay must play no part whatsoever in access to these services.

2. Fragmentation - the health service must be integrated and comprehensive.

3. Prevention - the emphasis must be on prevention rather than cure.

4. Rural services - rural areas must rapidly attain levels of care appropriate for the population they serve and at least comparable to services available in urban centres.

5. Affirmative action - historical inequities must be reversed in education and training of health personnel and in the delivery of health care.

6. All investments and services must be subjected to **cost-benefit and cost-efficient** analyses.

7. Priorities must be set for every level of health care on an objective basis.

8. A subcontinental perspective should be developed after appropriate consultation, with regard to needs for high-tech, expensive and tertiary care facilities.

9. The process of change should be non-punitive, should retain infrastructure as far as possible, without sacrificing the above principles. In addition, the process should be gradual, should adopt subtle or indirect means of attaining objectives instead of confrontation and rigid adherence to pre-determined views.

III. Reconstruction policy

1. Adopt a policy: This policy should be adopted publically as a broad statement of principle placing a high value on health, accepting that health is a basic human right and that all citizens are assured equal opportunities and equal access to resources which enable them to avoid preventable diseases, reduce sickness and disability, promote well-being and to achieve good health.

The policy should be incorporated

into a:

i. Bill of Rights
ii. Constitutional Rights to Health and Welfare.

2. Establish single Ministry of Health and Welfare in a National Health System.

Functions of the Ministry would be to:

a) Establish guidelines in Health
b) Establish a global allocation of resources
- abolish 14 ministries;
- appoint one Director-General of Health;
- establish Regional Administrative Units according to logical geographical divisions of the country.

A Regional Allocation Work Party should be established to decide on resource allocation according to population size, morbidity and mortality criteria.

Set up appropriate local authorities.

3. Community participation

Methods to encourage, nurture, or establish grassroots structures among communities should be sought in order to increase involvement of the masses. Both providers and recipients of health care should be organised so that their perspective can be heard and accommodated.

4. Comprehensive planning

Create a national commission to formulate a single comprehensive Health and Welfare Plan for South Africa into the 21st century.

5. Establish a Committee for Inter-disciplinary Co-operation and Planning to include the following areas:
- Primary Health Care
- Health and Welfare (especially social welfare)
- Education
- Finance
- Land distribution; agriculture
- Food security
- Income and Trade
- Mass Organisations
- Political Organisations
- Voluntary Organisations

6. Training personnel

Regional Commissions on Health Personnel Needs (according to central guidelines) and related Regional Commissions on Education and Training of Health Professionals could be formed. Their tasks would be, amongst others, to:
- determine appropriate personnel needs and thereafter appropriate training for personnel;
- introduce integrated health sciences facilities (instead of separate training schools for different health workers);
- explore alternative training models for all levels of health professionals.

7. Primary Health Care

a) Regional assessments of Preventive Health Care needs could be undertaken. To ensure that this is a priority function, a separate budget could be allocated for these needs.

b) A Primary Health Care Development Commission to establish priorities for children and adults could be established. Their tasks would involve support to education, consultancy, research, PHC projects. A budget should be established as a matter of urgency for PHC needs, infrastructure and planning. Consultation should take place with grassroots/advocacy groups such as PHC committees in rural areas and city health committees in urban centres.

8. Secondary and Tertiary Care

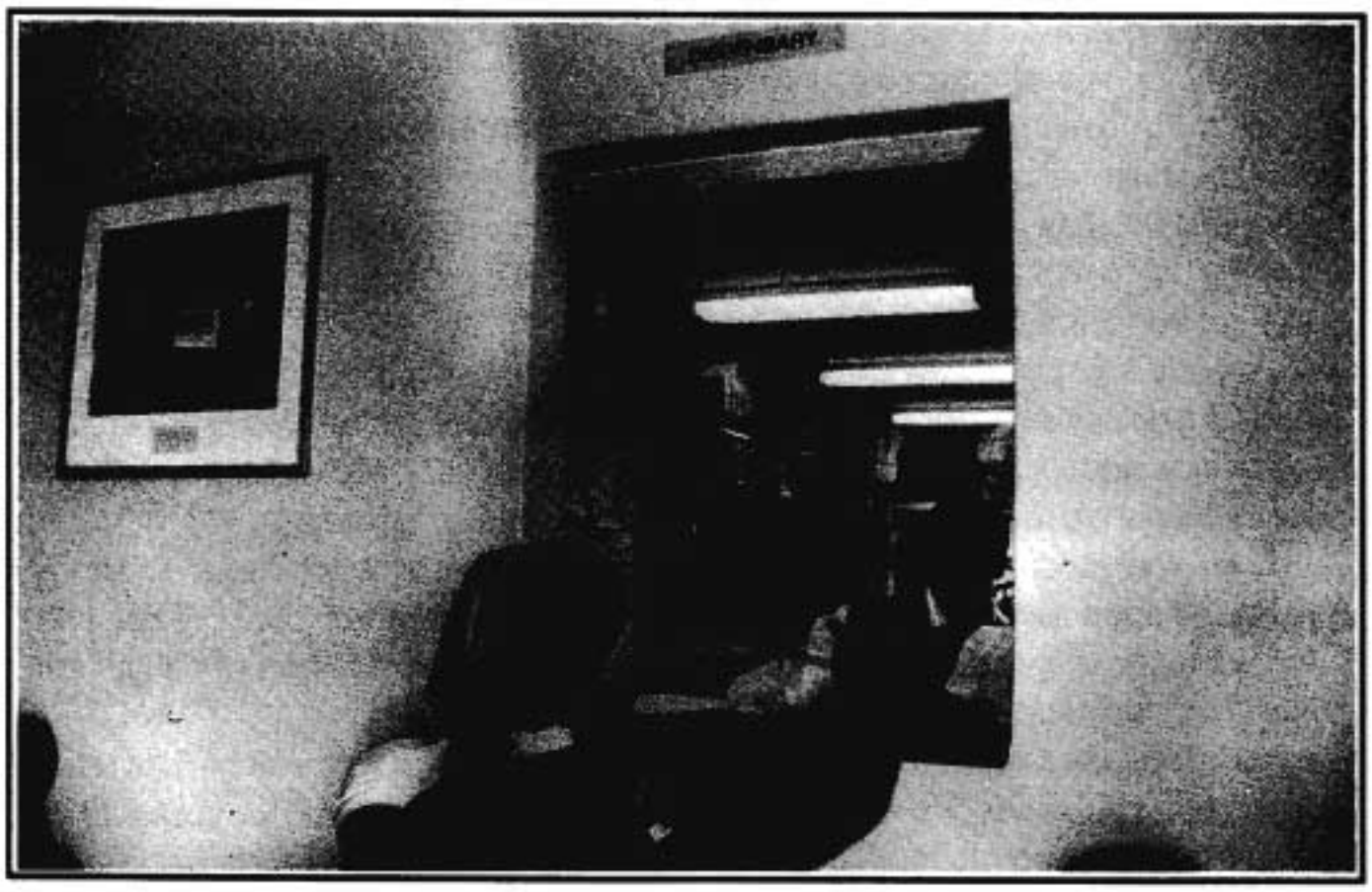
Regional assessments of secondary level and tertiary health care needs are required. A National Commission on Assessment of Priorities for Tertiary Care should undertake cost benefit, cost effective analyses, should have a subcontinental perspective and should formulate a budget for tertiary health care. Again, a participatory method of need determination should be the guiding principle when determining community needs.

9. Pharmaceuticals

A National Commission on Pharmaceuticals and Medical Supplies should establish:
- an essential drugs list for all levels of care;
- a national purchasing facility;
- a distribution network;
- ensure security of supply and storage;
- monitor quality.

IV. Context of new policy formulation

These policies must be implemented within a framework of national progress and development, elements of which impinge directly and indirectly on health and well-being. Such elements include:
- Improvements to the physical and social environments such as housing, education, welfare, sanitation, water, electricity, transport, communication, recreation, protection of the environment and the workplace and so on.
- Economic growth and redistribution such as the restructuring of the economy, land reallocations, improved income, workers' rights.
- Democratisation of the political process and empowerment of the people.
- Security and peace. ❑



A national commission on pharmaceuticals and medical supplies should establish an essential drugs list for all levels of care.

Financing health care for all

Is national health insurance the first step?

By Cedric de Beer and Jonny Broomberg

"Political changes in the next few years are likely to produce demands for the development of a health care service more in keeping with the principles of social justice. One urgent problem is the limited resources to meet these demands."

Inequalities in access to health care between white and black, rich and poor and urban and rural communities in South Africa have been well documented in recent years.[1,2,3]

Political changes in the next few years are likely to produce demands for the development of a health care system more in keeping with the principles of social justice. One urgent problem confronting us is the limited resources to meet the consequent explosion in the demand for health care.

In 1987 South Africa spent 5,8% of its Gross National Product (GNP) on health care. Of this, 44% was spent in the private sector which cares for perhaps 20% of the population. The remaining 56% was spent on the care of that 80% of the population dependent on the public sector.[4]

This 56% amounts to 3,2% of the GNP, which is below the WHO (World Health Organisation) minimum target of 5%. The expenditure in the private sector while substantial, does not contribute significantly to meeting the health needs of the population as a whole.

Given that major economic growth is unlikely in the next decade, and that substantial resources need to be diverted to other social priorities, we will soon be facing two uncomfortable challenges: we will have to expand the range and quality of service provided without any significant expansion in resources available to do so; and, as a direct consequence, some way will have to be found to draw those resources currently expended in the private sector, into a carefully constructed system which aims to provide adequate health care for all.

In this article we argue that the implementation of a national health insurance programme would be a significant step towards meeting both these challenges. We suggest that through such a mechanism of centralised control of health financing, privately owned facilities and private practitioners will best be integrated into a national health system.

The case for central funding

Most writers distinguish between private and public sources of finance for health care.[5]

The most important private sources are individual out of pocket payments at the time of service, and contributions to private health insurance.

The two most significant sources of public financing are tax revenue and a centrally regulated system of public health insurance.

A fundamental principle of social justice in health care is that access to care should not be determined by factors such as wealth, race or geographical location. Attempts to fund health care from pri-

The MDM protests against segregated hospitals during the Defiance Campaign: race, wealth or geographical location should not determine the access one has to health care. Funding health care from private sources is likely to contravene this basic principle of equity.

vate sources are likely to contravene this principle of equity.

Health care needs are often unaffordable to individuals if they have to pay the full cost of treatment as it occurs. Financing health care through user fees means that many people will not be able to afford the care they require.

Private health insurance has developed to protect individuals from sudden major expenditure. Almost all such private insurance is linked to employment, since the cost is shared by the employer. Where individuals pay the full cost of membership of a medical aid (insurance) scheme, the contributions would be unaffordable to the majority of citizens of South Africa.

Thus private health insurance also offends against the principle of equity on the grounds of affordability, especially in a country such as South Africa where there are large numbers of people without jobs.

Funding health care from private sources is also likely to lead to the development of two separate systems of health care: a luxurious private sector serving the privileged few, and an underfunded public sector providing inferior care for the majority. This leads to an excessive concentration of health care facilities and health care providers in those centres where the private contributors are most densely situated. This has clearly occurred in South Africa.[3]

Administrators of private medical insurance have an interest in excluding high risk patients from membership, since insurance schemes wish to avoid paying the medical bills for high risk patients, in order to keep premiums as low as possible. The result is that higher risk patients can only get care at considerably higher premiums. It is worth noting that risk ratings are being introduced into the South African medical insurance world since the relaxation of certain regulations governing medical aid schemes in October 1989.

Privately funded care almost inevitably pays only for curative health care. There is very little incentive for any individual to pay for preventive measures, in which the social benefits tend to be greater than the benefits to any particular individual. Thus the state is left to subsidise the preventive health care of privately insured individuals.[6] This leads to an unnecessary separation of preventive and curative services.

The existence of multiple private insurance agencies is itself an additional form of fragmentation. It makes it extremely difficult to develop and co-ordinate policies aimed at rationalising the provision of health care. The existence of more than 200 medical aid schemes in South Africa is a case in point.[7] The existence of multiple insurers also adds to overall administrative costs. It must be cheaper to administer funds through a single agency than through 200 different ones.

A single, centrally co-ordinated mechanism paying for health care has the potential to avoid most of these pitfalls, and has some additional advantages.

Where the vast majority of funds for health care are centrally co-ordinated, a two tier health care system is far less likely to develop. Where large disparities in the quality and quantity of care have developed, both regionally and in terms of social class, only a central funding agency will be able to reallocate priorities, and to direct growth financing to underdeveloped areas.

Thus a centrally co-ordinated funding mechanism which is established to finance health care for all has no interest in excluding anyone from access to health care, avoids unnecessary administrative expenses[8] and has the capacity to encourage the integration of curative, preventive and promotive health services within the same administrative structures.

Options for central funding

The funds to pay for central funding must come from the general tax revenue available to the government, or from some additional contributory scheme, such as a national health insurance scheme, in

which those in formal employ are compelled by law to contribute to a national fund. Employees' contributions may be matched by employers. The money thus raised may be administered as a separate fund to pay for the health care of contributors, or it may be pooled with other sources of revenue and used to pay for the health care of all.

At a certain level of abstraction, the differences between these two systems begin to blur, on the one hand, compulsory health insurance is simply a form of payroll tax shared between employers and employees, and the only difference between this and other forms of tax is that it is earmarked to pay for health care.

On the other hand, in some health insurance systems the state pays, out of general tax revenue, the contributions of those who are unable to pay for themselves.

Nonetheless, the systems are identifiably different, and their relative merits are argued persuasively by their respective proponents.[10,11,12,13]

The arguments for taxation

Those who support taxation as the major source of central funding argue that, from the point of view of efficiency, no additional structures are needed to raise or administer the funds. Tax revenue remains directly under the political control of central and local government structures which are more directly accountable to the people served.

The critics of national health insurance point to insurance systems in which the funds generated are controlled by Departments of Labour (thus fragmenting health services) or by some administrative structure which is not politically accountable.

It is argued further that because health insurance contributions in developing countries come largely from an employed urban elite, they may pay for health care in which undue emphasis is put on curative care, resources are focused in urban areas, and a two tier system often develops with far better care available to those who contribute to the insurance system.

Thus, it is argued that a health service funded almost exclusively from tax revenue, and open to all citizens equally, is the neatest, most equitable and probably the most efficient way to pay for health care.

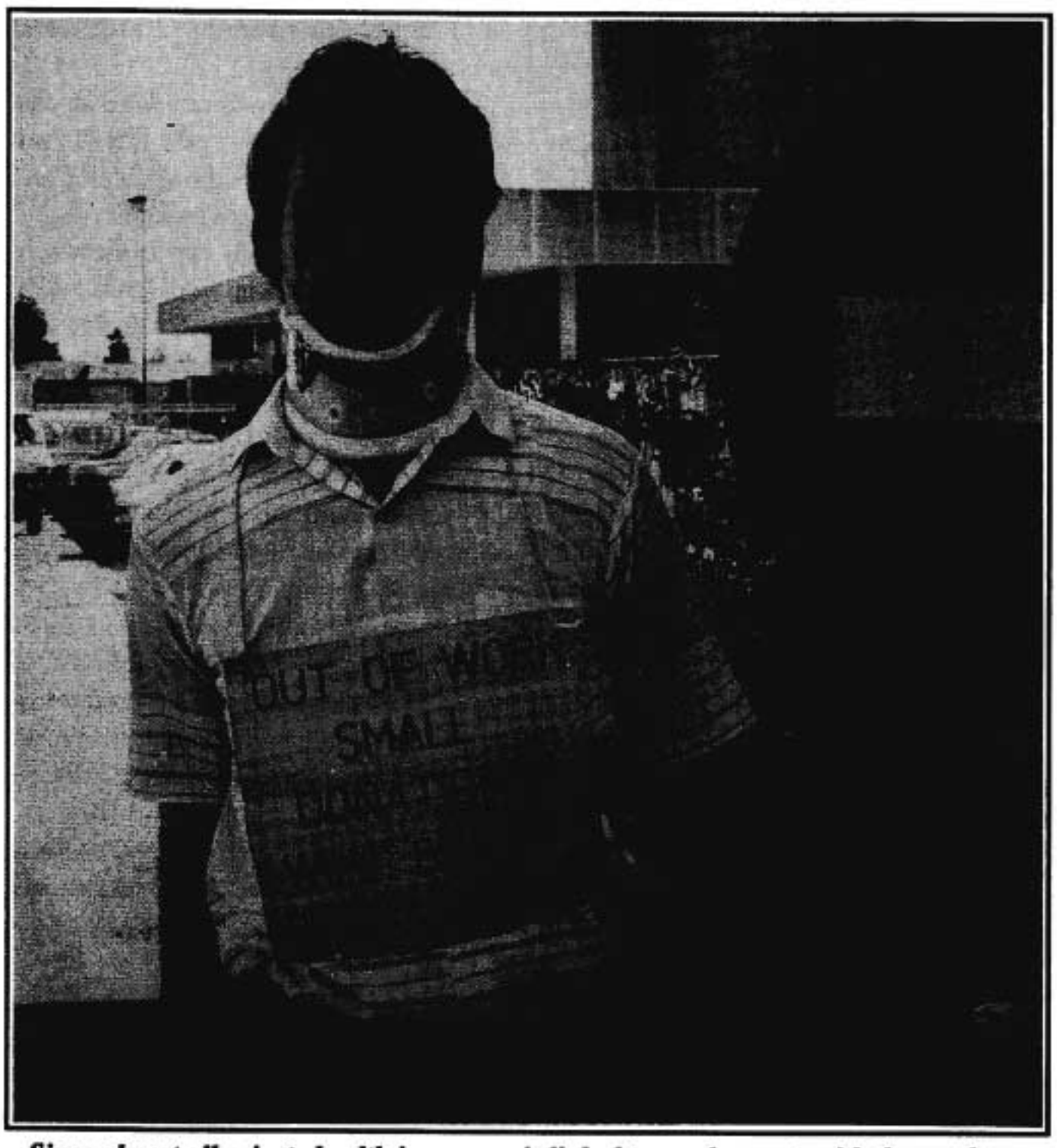
The arguments for health insurance

The proponents of national health insurance argue that it is the most politically acceptable way to mobilise additional funds to pay for health care. In developing countries, there is usually a low ceiling on revenue that can be raised from income tax. Other forms of taxation such as sales tax tend to be regressive, penalising the poor more than the wealthy. It is easier to convince the relatively well off to make additional payments earmarked specifically for health care, than to increase income tax to pay for expanded health services.

In addition, these earmarked funds are relatively well protected against any impulse to cut funding for health care in times of economic recession.

Finally, the proponents of national health insurance argue that, no matter how desirable it is for health care to be funded by taxation, all tax-based systems have in fact evolved out of health insurance schemes. Therefore, health insurance becomes a necessary stage in the transition from privately funded to tax funded systems.

The arguments on both sides have their merits. The choice of system therefore must be influenced by the context in which a decision has to be made, rather than by any theoretical advantage of one system of funding over another.



Since almost all private health insurance is linked to employment, with the employer paying part thereof, such insurance will be unaffordable to the large number of unemployed in South Africa.

The South African context

It is unlikely that South Africa will be able to spend much more than 6% of its GNP on health care, and we argue that it would be undesirable if almost all these resources were controlled by a central co-ordinating body. Yet the reality facing us is that almost half of the funds available to pay for health care currently come from private sources, and pay for the private care of a small, privileged elite.

The question facing us is: how do we

achieve the central control over funding necessary to create a more equitable system of health care?

It appears that there are two possible courses of action:

- Expand tax revenue by several billion rand and pay for all health care out of taxes. This would leave untouched the funds currently paid to the medical aid schemes.
- Find some way to ensure that the money that people are currently paying directly to the private sector, is rather paid into a central state fund.

The other social priorities faced by the state means that raising the additional finances that will be required by the health sector will be very difficult. In this context, it seems obvious to us that the latter course of action should be chosen.

Legislation compelling employers and employees to contribute to a national health insurance scheme would work in much the same way as present contributions to medical aid schemes. The difference is that membership would be compulsory, and payments made to the Department of Health, rather than to the private medical aid societies as at present.

The state would define a fairly comprehensive package of health care that would be available free to all including the unemployed. All health services within the package would be paid for out of the combined tax and health insurance funds.

Thus it seems to us that national health insurance is the logical first step on the road to paying for health care for all.

Clearly the implementation of national health insurance will not guarantee an appropriate and socially equitable health care system. Other major developments are required such as the dismantling of all apartheid structures, the creation of greater administrative efficiency, and a commitment to comprehensive health care with sufficient emphasis on the prevention of disease and the promotion of good health. These prerequisites are beyond the scope of this paper.

What about the private sector?

A basic aim of centralised state funding is the progressive eradication of the two tier health care system. If this is to be achieved, it must not be possible for relatively privileged strata of society to pay for their ordinary health care needs in a system from which others are excluded because they are unable to pay.

In 1987 SA spent 5,8% of its GNP on health. 44% went to the private sector, catering for 20% of the population. The remaining 56% was spent on the care of the 80% dependent on the public sector.

This means, by definition, an end to the medical aid system as we know it. Private health insurance could only be permitted to pay for services not available within the package of care paid for by the national insurance system. The exact process by which the medical aid funds were dismantled, or incorporated into the national health insurance system would need to be negotiated and is also beyond the scope of this paper.

Whatever the desirable end point, health care planners will have to accept the continued existence of private hospitals and private practitioners for the foreseeable future. Without careful regulation, this private sector will perpetuate serious inequalities in the health sector.

The centralisation of funds in the hands of the Department of Health could provide this major mechanism for the effective regulation of private providers of health care. As the sole payer for health care, the department would, for example, be in a strong position to:

- ☆ Bargain with private providers over payment, prescribing patterns, referral and treatment policies, etc.
- ☆ Prevent the private sector from expanding in already well served areas.

Conclusion

The implementation of a statutory national health insurance scheme is a politically feasible way of moving towards greater equity in the health care system. It is a proposal that is likely to be acceptable to a wide range of interests including employers, employees, almost all users of the health service and many health care professionals.

Opposition to the proposal may be expected from the medical schemes and the private hospitals. Some private practitioners, however, would benefit from guaranteed payment for the agreed package of services, through a system substantially simpler than the present network of medical aid schemes. On the other hand, many of the social goals desired by the proponents of nationalisation, may well be achieved through a national health insurance system.

We believe it is an idea worth putting on the agenda for debate, refinement and negotiation. ❑

Acknowledgements

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Is there a role for the private sector in SA health care?

Yes, but not in the NHS

By Merrick Zwarenstein

Introduction

In this article I argue that there will be no role for the private sector, as we see it today, in the kind of National Health Service (NHS) needed to answer South Africa's priority health and health care needs.

Definitions

The *"National Health Service"* is the collection of staff, resources and money under the control of the department of health of a democratic government. It will be committed to the Primary Health Care Approach of the World Health Organisation, and will have the goal of meeting priority national health and health care needs first. These priority health needs are likely to be diseases which can be prevented or treated relatively cheaply, and which affect the poorer and disadvantaged classes and groups in the society. Examples are immunisable diseases in children, cervical cancer, AIDS, and occupational illnesses.

The *"private health care sector"* here includes health care providers or companies which provide health care without being under the direct control of the government. The orientation of this care is strongly influenced by the financial interests of the provider, focuses on the individual consultation or care event rather than the person or the community, and will not spontaneously support the PHC approach.

The term *"no role..."* implies both separation from the NHS, and consumption of a small fraction of total national health care resources and expenditure as in the United Kingdom, a country with an NHS, where the private sector is only used by about 15% of the population. Even this group obtain most of their preventive, sophisticated or emergency care from the NHS. Private care is separated from NHS care in the UK.

The present pattern of public and private care sectors

The public sector has widely varying coverage - from urban to rural areas, white to black communities - as well widely varying levels of sophistication - from teaching hospital to rural clinic care. Access is based on one's total household income and accommodation is not luxurious. The private sector is even more unevenly distributed, essentially providing only a luxury service, mainly in urban areas, with a tendency to overtreat, and accessible only to people with money or expensive medical insurance ("medical aid").

The goal: equity, efficiency, effectiveness

We want to move towards an NHS open to the whole population, acceptable to users, accessible financially, nearby, and welcoming, fairly distributed across the country and between all identifiable population subgroups according to health needs, efficiently managed, and applying only those kinds of medical care which are known to work. This NHS would make best use of national health care resources for the population, with a balance of health promotion, caring, and curing.

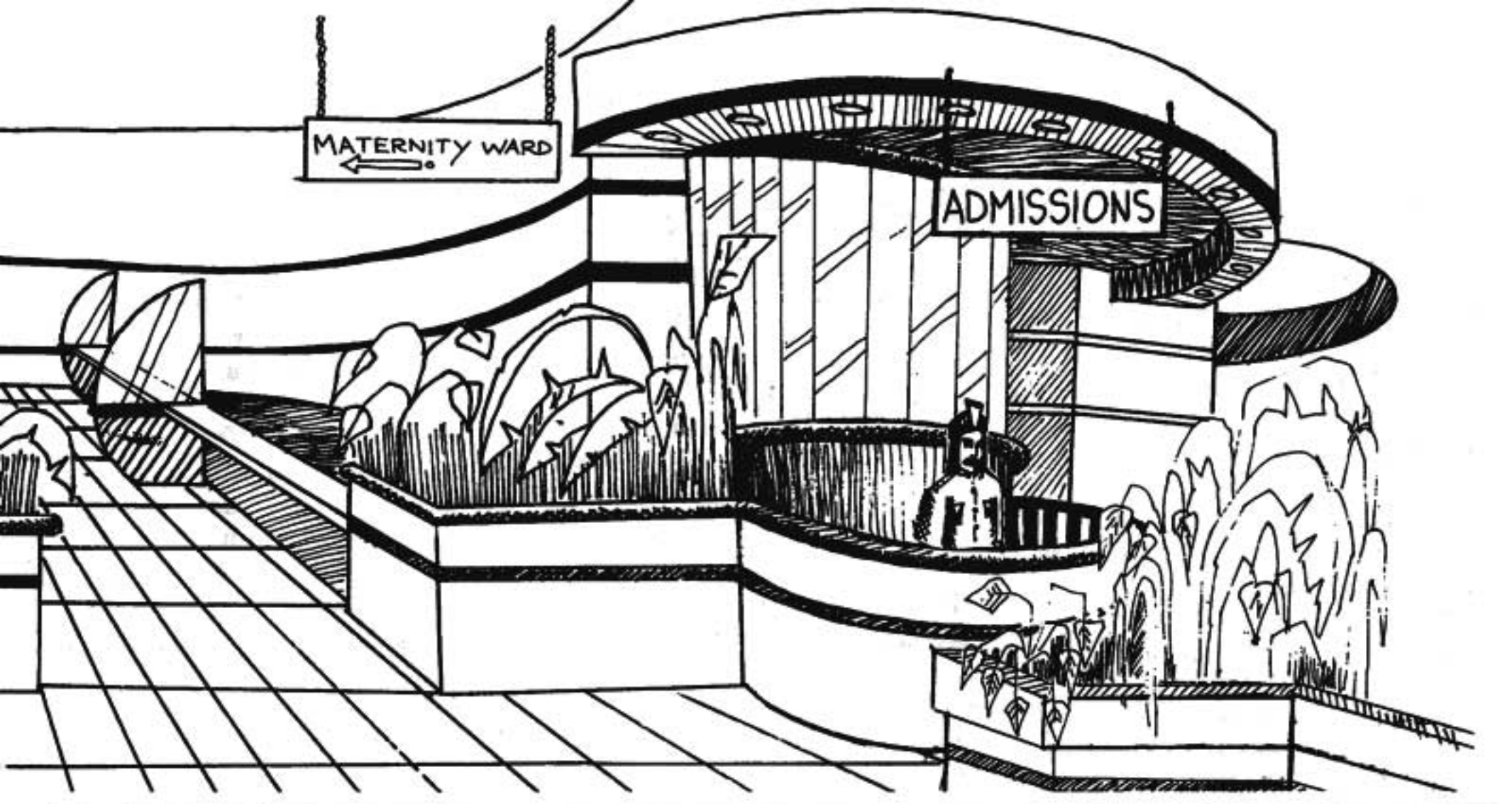
How do we build an NHS?

The political context

The social and political transition in South Africa is occurring over a period of several years, and does not include a wholesale surrender of white controlled assets. Because the existing state and ruling groups are negotiating transition, rather than simply handing over control, there is modest flexibility in political, social, and economic conditions for the new government in dealing with high popular expectations.

Nationalisation

Wholesale nationalisation of private health sector assets, and forced public sector employment of skilled people is not an option. The are in any case many disadvantages in such a strategy - hostility, sabotage, emigration. Since the purpose of the nationalisation is to redistribute



resources and change services to meet priority needs, and since this requires willing providers, frontal confrontation would be self defeating.

Will national health insurance lead to an NHS?

The countries which have moved towards universal entitlement to health care in a unitary national system have, with the exception of Cuba gone via a national health insurance scheme. NHI is a method of financing health care. A government controlled insurer regularly collects money from all employed people and their employers, adds to it money collected by the government from tax, and uses both these amounts to pay health care providers for a negotiated set of health care available as a right to every citizen.

Improvements in the type of services, and distribution and efficiency of health care under this private provider dominated system are through indirect leverage. Control of behaviour of health care providers is obtained through modifications in the amount and form of remuneration. This is more difficult if the PHC approach is the national plan, because its many interdependent programmes will have to be broken down to individual items for negotiation (and perhaps payment). This especially affects doctors, since even in the USA nurses are predominantly salaried employees, and therefore easier to influence directly. Indirect leverage is weak, and may have undesirable side effects. After 15 years of expensive development, insurers in the US have partly controlled overservicing, only to find underservicing emerging as a new route by which the medical companies attain their profit ratios.

Ensuring quality care under an insurance system would be a continuous struggle between the insurer and the providers.

How would a public sector based NHS develop?

Direct control is likely to be the most feasible way to modify the health service to improve its efficiency, effectiveness and coverage.

A public sector NHS, under the control of a democratic government, can plan and implement for national priorities. An NHS with a large private sector will not be able to do this because the private sector elements are not committed to national health priorities and plans and will not accede to them unless they are modified to accord with their special group interests.

I therefore argue that SA should build an NHS from the public sector alone, rather than from a combination of public sector and private sector providers.

Public sector financing of public sector care, direct public sector hiring and direct control over public sector facilities and providers of health care are the basis of effective policy implementation. There are functions where a state wants to implement policy smoothly and directly. Examples are the defence and justice functions, which are never left to the uncertainties of indirect control.

South African health care needs significant improvement. This will be difficult in the absence of smooth and direct control. The NHS would need to develop PHC, with prevention and health promotion activities. The service must use a team approach, with an increased role for both non-doctors and non-professionals. Active community participation and control in local health care would be emphasised.

Improvements in management, morale, resources, and community participation could help keep professional staff, and bring back some of those attracted by the slightly better salaries and working conditions that the private sector has had.

The transition period

South Africa should invest political and financial capital in its NHS in the early years of the new government, coinciding with the period of maximum potential for social interventions.

Patient's experiences of private sector health care have been fairly unhurried, related to minor conditions which seldom reveal the inadequacies of the system, and accompanied by the respectful ear of a skilled doctor whose attention is sharpened by the knowledge of a fee.

Contact with the public sector outpatient service has usually been hurried, production line, and accompanied by the displaced aggression of pressurised staff. Public sector services, which could well use the known efficiencies of appointment systems for outpatients, seldom do, and in the frenzied rush of the crowd, it is not surprising that patient believe the service they receive matches its poor presentation, and is of poor medical quality.

The private health sector should not be closed, nationalised or incorporated into the public sector. On the contrary, aside from medical technical issues, such as safety and quality of care, it should be left almost wholly to its own devices, and the unpredictable nature of the market, entirely separated from the NHS (and from the public subsidies on which it depends). The goal is to limit the growth of the private sector, turning it towards a marginal provider of a small range of luxury services. The desire of some patients to buy private medical services should be respected.

When the presently voracious private sector is brought against its own limitations, when interest groups are fighting with each other over the leaner pickings of an unsubsidised and smaller market, it is likely that individual practitioners and some companies will want to move into or sell out to the public sector.

Until that collapse it is in the best interests of the majority of the population to spend scarce resources of skill, planning ability and money to build up the public sector into an effective, accessible and efficient health care service for all the population who need it.

Strategies for dealing with the private sector

Four active interventions that will affect the private sector come to mind:

Audit and quality control

The country needs to detect, publicise and disallow or at least discourage harmful practices in the private and the public sectors. Examples include unnecessary procedures and inappropriate drug prescriptions. This quality control is likely to be easier in the public than in the private sectors, and the failures in the latter will help to dispel the unchallenged image of infallibility which it carries.

The private sector should not be closed, nationalised, or incorporated into the public sector. It should be left to collapse under the weight of its own limitations.

The medical insurers who will remain should be enabled by the state to police overservicing and conduct other assessments of the private sector providers. As in the United States, this will discourage excessive expenditure in that sector, as well as expose it to the trauma of the real economic world.

Licensing capital investment

The United States licenses the opening of beds and new technology, in both public and private sectors according to need. Successful control over the bed supply, and failure in controlling physician placements and practice explains the mixed picture in the Canadian health economy. South Africa should do the same, including a retrospective review of existing facilities for need.

Removing the tax subsidy

The public purse subsidises private health care via the tax rebate on corporate contributions to medical aid for employees. This rebate could add about 20% to the public sector health budget.

Moving public sector employees off medical aid

Public sector corporations employ about one third of all medical aid members, and therefore provide a large part of the market. These corporations could be required to collaborate with the NHS-to-be to provide public sector health care at the workplace. There are many work sites where the concentration of employees is large enough to supply a full range of public sector services. In appropriate instances, these could be open to the public in the immediate vicinity.

Ending subsidised staff training

Medical and nursing staff are trained with a subsidy from the public purse. It is difficult to make a uniform case for the private sector to repay the cost to the NHS of hiring away a trained person from public sector work, since there is no intention of doing this for other professions or trades. It might be feasible to do this for a period for certain scarce professions, such as nursing. In the longer run the general subsidy could be removed from training, and replaced with bursaries for students who are prepared to pledge themselves to enter public service.

Summary

The NHS South Africa needs can only be built on the foundation of the public sector.

The private sector, especially if strengthened by an influx of national insurance money, will be a growing and uncontrollable sink for money. This money has better uses. The conflict with the private sector needs to be minimised, and conducted from the high moral ground.

More research is needed. We must move beyond rhetoric, to detailed policy proposals with empirical assessments of feasibility. ❑

Acknowledgements

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The people on this list are not responsible for errors, nor do they necessarily agree with the point of view expressed; this is work in progress, and incomplete. Empirical research on how National Health Insurance or a National Health Service might operate, be financed, controlled or evaluated has hardly begun.

Addendum

This paper reflects my personal opinions and not necessarily those of any organisation of which I may be a member or an employee.

RESTRUCTURING AND FINANCING OF HEALTH AND WELFARE SERVICES

The Maputo Conference devoted a number of days to the challenge of restructuring and financing of health and welfare services, tackling policy issues broadly and more importantly, looking at some of the practical issues as well.

Papers presented covered both aspects - financing and restructuring. Delegates initially divided into four "buzz groups" to highlight what participants perceived to be key issues to consider.

Two separate workshops were then held - one on financing and the other on restructuring. Inputs were given from both the health and the welfare sectors.

THE BUZZ GROUPS

Participants identified the following areas for further examination:

- urban-rural bias
- the nature of financing health and welfare services both at present and in the future
- community involvement and community financing
- identification and redistribution of fixed resources
- determining minimum welfare needs
- mechanisms for restructuring
- the role of the private sector
- the relationship between primary health care and tertiary care
- the role of the worker organisations in restructuring health and welfare services

The fact that resources available to redress the inequalities in health and welfare would be limited (one paper gave a figure of R10 billion to achieve instant parity in welfare alone!) highlighted the need for realistic expectations to be put forward to people's organisations. This need underpinned much of the discussion and papers at the conference.

THE WELFARE SECTOR

The input from N. Hlatshwayo of the ANC, emphasised the existence of welfare as an integral part of any socialist system. A people's government will intervene and dismantle the racist welfare system, provide a national health service and free welfare. The importance of the role of people's organisations was stressed. Mass participation in the mobilisation of the working class for services, facilities and benefits, is a tradition that would strengthen and deepen a genuinely democratic people's welfare system.

A. Letsebe and J. Loffel presented a paper on restructuring welfare services providing practical, effective and immediate steps for restructuring.

They raised the advantages and disadvantages in a separate as opposed to a unitary ministry of health and welfare.

Welfare workers maintain a need to increase the number of registered social workers from the present 6 000 to 21 000 by the year 2000. Training programmes of social workers and other welfare personnel need to be reviewed and should contain a political content.

The distribution of resources amongst different authorities - "racial" and geographical - that a future post-apartheid government will inherit, will be the backlog against which we will have to move towards equity. What extra resources are available for redistribution after eliminating fragmentation? What welfare services can the country actually afford on an equitable basis? These questions were dealt with in a paper by F. Lund.

THE HEALTH SECTOR

The first paper, by H.M. Coovadia, detailed the important aspects of a new health policy for South Africa. The need to involve organisations, build equity and concentrate on prevention, was emphasised. The paper argued that a new health policy must have:
- an affirmative action programme
- a statement of principles including a bill of rights
- a single ministry of health with central planning but decentralised functioning. This must include participation of grassroots organisations.

The second input, by B. Kistnasamy, addressed the practical steps that can be taken to decrease morbidity and mortality from common diseases. The authors argue that the major intervention will involve the use of Primary Health Care (PHC) but maintain that PHC will fail if it concentrates only on providing essential health services. Rather it should envelop a militant concept aimed at redistributing power and resources.

As a first step, the Progressive Primary Health Care Network (PPHCN) and the National Emergency Service Groups (NESG) need to be strengthened as they are currently involved in work of this nature.

Mass-based campaigns (including media and involving key members of the liberation movements) are needed as is the involvement of civics in health so that mass based struggles can make a firm input into health campaigns such as mass immunisations.

Setting targets (e.g. 75% of population immunised in first year; 90% in second) and the creation of a pool of human and material resources during the transition phase was highlighted as an important interim measure.

The third paper, given by Rob Davies, of the Department of Economics and

Delegates discuss issues raised at the conference.

Planning of the ANC addressed the socio-economic framework within which restructuring could take place. The paper argued that there can be no equitable health service without a democratic transformation of the economy while recognising that productivity cannot be raised and people's creative energy unleashed unless the population is healthy. Thus an equitable system is an essential element of a programme of economic transformation.

There is a need for democratic transformation with affirmative action aimed at redressing economic problems facing those disenfranchised by apartheid.

While the goal of transferring the existing monopoly industry to the ownership and control of the people remains a long term aspiration, the degree of state intervention necessary to redress the current problems cannot be reduced simply to nationalisation. The ANC is committed to promoting economic growth, but this must benefit the majority. The mixed economy approach means that the movement recognises the private sector to have an important role. However, companies should respond to the interests of stakeholders other than shareholders - this includes workers, consumers and the community. The ANC is committed to the establishment of democratic structures which will permit a broad national debate on economy and other aspects of policy.

In group discussions that followed the papers, the need to link health and welfare was emphasised. Welfare workers indicated that they felt marginalised by the medical orientation of large parts of the proceedings. The groups felt that greater emphasis should be given to welfare research.

RECOMMENDATIONS

1. The space provided by the present political situation should be used to "engage" the state and the conservative professional bodies such as The Medical Association of South Africa (MASA) and the South African Nursing Association (SANA).

State facilities should be used on condition that regular mandates are obtained from community organisations. The agenda of the progressive organisations should guide such engagement.

2. Develop the PPHCN. Draw social workers into the structure.
3. Restructure training of health and welfare personnel and look at ways to redirect personnel to rural areas.
4. Place health and welfare on agenda of mass organisations. Work with a wide range of community organisations and trade unions. Mobilise against new welfare legislation, intensify the defiance campaign. Mobilisation should take place at a local level around concrete, realisable demands.
5. Address the hegemony of medical over social services. Progressive health projects to start incorporating welfare issues into their programmes.
6. Redirect more research towards welfare issues.
7. Support progressives working in voluntary welfare organisations, eliminate racism in welfare structures.
8. Integrate our short-term programme for transition with a strategy for the future, in one process.

"Primary Health Care should not concentrate only on the provision of services. Rather it should envelop a militant concept aimed at redistributing power and resources."

The impact of workers' demands around health and welfare issues needs to be carefully examined.

AREAS FOR RESEARCH

- What formulas can be used for determining welfare (and other) subsidies?
- What alternative models exist in other parts of the world?
- What mix of private and public sector health care is appropriate for South Africa?

FINANCING HEALTH AND WELFARE WORKSHOP

The papers and discussion in this workshop focussed primarily around two areas: the role of the privately owned health sector and the responses to the privatisation strategy of the state.

M. Price presented a paper that outlined the different sources of funding for, and ownership of, health services and clarified the meaning of terms such as "privatisation" and "private funding", so that discussions could revolve around a common understanding of the terms used.

The paper, by C. de Beer and J. Broomberg argued for a national health insurance as the first step towards financing health care for all. The centralised control of health financing would be the best mechanism to integrate privately owned facilities and private practitioners into a National Health Service (NHS).

The next paper by M. Zwarenstein suggested there was no place for the private sector in the NHS. He argued that the private sector was found wanting when evaluated against standard indicators of health care and in the process of transformation, the strategy should be directed towards strengthening and building the public sector, while leaving the private sector untouched. Legislation should, however, be introduced to prohibit the entry of future medical students into private practice and to control unnecessary procedures being performed - such legislation, together with the ripening of the internal contradictions of the private sector would lead to its eventual demise. The underlying assumption of the position was that direct measures against the private sector would result in major political battles which a new state would be in a poor position to take on.

The participants in the workshop were in agreement with the notion that there was no place for the private sector in a future NHS. There was, however, general disagreement with the strategy proposed, namely that of leaving the privately owned sector to "die out", for the following reasons:

1. The private sector would continue to undermine the public sector.
2. A large percentage of health workers are in the private sector and serving only a small section of the population. Measures must be taken so that they begin to serve the needs of the majority.
3. From a financial point of view, resources currently in the private sector (50% of the total health expenditure) needed to be appropriated for general use in a common pool. This was felt to require centralisation of financing and the proposal of doing this through taxation or a National Health Insurance Scheme was reiterated. The process would necessitate curtailing and

regulating private medical insurance.
4. It was felt that the experience of many countries in Africa had shown that coercive measures directed at private practice would not work (e.g. banning entry would increase the brain drain and stimulate a parallel black market).

The discussion then turned to ways of incorporating and controlling the private sector. It was agreed that the main instrument of control should be incentives. These could be financial and other, e.g. improvement in working environments. The style and quality of the public sector would have to be improved so that health workers are attracted to work in this sector. It was agreed that while some regulation would be needed, these should be used with care.

A period of compulsory rural/community service for graduates was seen to be a useful strategy.

RESPONSES TO PRIVATISATION STRATEGY

The second major area of discussion was around the responses to the privatisation strategy of the state.

An input by J. Broomberg pointed out that the aim of the privatisation initiative by the state was to "off-load" responsibility for health/welfare provision onto capital/individuals.

The increasing demand for medical aids via the trade union movement and the dilemmas it posed, were outlined:

On the one hand, offering such benefits contributed towards addressing the material needs of workers and strengthening the unions. But, the provision of such benefits to workers only (by excluding the unemployed, etc) is leading to a stratification of the working class.

Participants agreed there was no easy solution to the problem. A number of different views with regard to how it could be addressed emerged. These included:
1. That workers should be educated to see their long term interest, and be urged not to join the medical aids.
2. That workers health schemes be seen as victories for the labour movement, and that it should be up to the future NHS/state to compete and provide more attractive alternatives.
3. That workers should set up their own health services in the form of benefit schemes. Such schemes, controlled by the workers could be more easily manipulated in the interim to minimise the stratification effect, and in the long term would provide an infrastructure which would be easier to transform into an NHS.

Views expressed against the last proposal included the fact that workers would acquire vested interests in their schemes and resist incorporation into a future NHS. A counter view to this was that unions should, for the interim, concentrate on the material needs of workers, and that it would be possible to inform the workers at the same time of long term political interests so that they would not resist incorporation into an NHS. Such education should be taken up by the workers' organs of political power such as the South African Communist Party (SACP).

The workshop did not resolve the issue, but highlighted some of the contradictions involved. The workshop further recognised that these contradictions were not specific to health but were seen in the social and welfare sector too.

Strategies aimed at strengthening the public sector and making it more attractive for both patients and personnel must be found.

THE WAY FORWARD

The workshop did not set out to develop definitive strategies for the future. It served primarily to deepen understanding of the problems faced in trying to transform the health sector and to identify areas for research and debate.

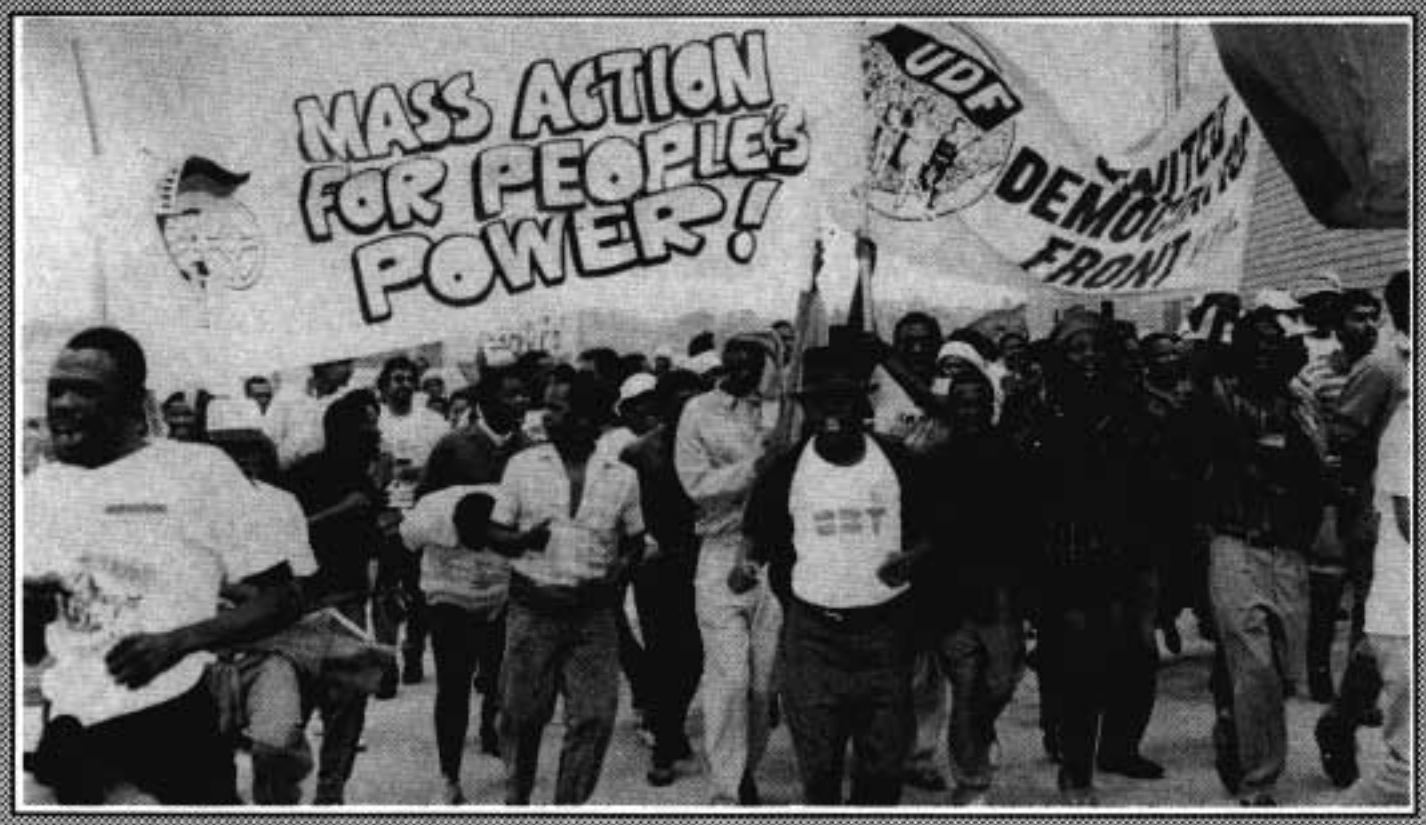
The following areas were identified:
1. The impact of workers' demands around health and welfare issues in terms of satisfying the needs of the working class in the interim and long term.
2. The development of strategies which would minimise/avoid stratification of the working class, and direct worker initiatives in keeping with the development of a national health service.
3. The applicability of various models of private facilities and private practice to the South African context.
4. Levers of control (economic, legislative, and other) which could be exercised over the private sector.
5. Development of strategies aimed at strengthening the public sector and making it more attractive for both patients and personnel.
6. Effectiveness and cost-effectiveness of various health care interventions.
7. Is a National Health Insurance the first step to financing health care for all?
8. The implications of foreign aid and programmes and possible problems involved.

RECOMMENDATIONS

1. A period of compulsory service to the state should be introduced for all health workers.
2. Debates on health financing must be contextualised in terms of the ANC's general economic thinking, and more specifically, in terms of the mixed economy debate.
3. The anti-privatisation campaign and the campaign for the NHS needs to be intensified by all political, worker, welfare and health organisations.

No final agreement was reached on the following resolution: 'In order to finance health for all, control of funding needs to be centralised, and financial resources currently in the private sector should be brought under control of the state'. ❑

HEALTH SERVICES & HEALTH CHARTER SESSION - OVERVIEW



Discussion in this session revolved around two main issues:
- The multisectoral nature of the health services;
- The importance of developing mass-based participation in health issues (with the discussion being focussed on the Health Charter Campaign.

The following points were raised in these discussions:-

1. Health issues and struggles need to incorporate other sectors, and should involve multisectoral approaches around health.

It was stressed that health needs to be incorporated into people's ongoing struggles, and that health must build-on and strengthen the political struggle. In particular it was suggested that health issues should be raised in worker structures.

The progressive Church is also an important sector with many resources and should be drawn more into the struggle for health.

2. Consideration was given to not privileging health demands over and above people's other demands such as for housing and a living wage. A realistic assessment of the economic capacity of post-apartheid South Africa will place limitations on the transformation of the health services.

3. The importance of developing mass-based and community-based participation and control over health issues was intensely discussed. The exact nature of the participating structures was not, however, resolved or developed. Suggestions for ensuring participatory democracy in health included:
- enhancing the current Progressive Primary Health Care Network;
- using the Health Charter Campaign as a vehicle for mobilising the masses around health;
- ensuring a unitary health system is decentralised at a community and local level;
- election of a democratic government that would be expected to represent the community, thereby facilitating community participation.

4. There must be a combination of mass-based participation in health and more "removed" research into health policy and the situation of health in a broader perspective of political, social and economic concerns. The example of the Centre for Development Studies (CDS) was cited as a vehicle for researchers to engage with community organisations in determining research areas and priorities.

5. The Health Charter Campaign (HCC) was presented as a way of mobilising the masses around health. Through this mobilisation the masses would be able to give political expression to their health needs.

The aims of the HCC are to:

A. To establish the demands of communities for improved living conditions, based on factors they identify as impeding the attainment of physical health and mental well-being. These demands, collated regionally and nationally, will thus represent the authentic and democratic health demands of the people and form the basis of a Health Charter.

B. To establish health sub-committees within the area committees serving the communities, which will serve as the basis for community-based health structures of a democratic health care system in the future.

It was recommended that the process of the HCC should be inclusive of the broad struggles of the people. It should strive to guarantee that the expectations of people around health are in keeping with the general capacity of post-apartheid South Africa to deliver on particular health demands.

The concept of such a charter was welcomed as a way of raising awareness of the broad community on health related problems but concerns around the campaign included the problem of the political affiliation of "Charter struggles", and that only a small number of our people are organised around "Charter" issues. It was felt that while we need to organise broadly around health issues, we should be mindful of the difficulties we are facing organisationally in health in particular and in communities generally.

7. The ANC gave an input about medical assistants trained in their ranks. There is a need to assess their curriculum and find ways of integrating these health workers into the body of health workers in South Africa. ❑

Personnel development for health in South Africa

By L.Rispel & H. Schneider

The current political changes in South Africa have highlighted the need for more detailed discussion and debate on the structure and financing of a future health and welfare sector, what personnel policies are needed and how the process of transformation will be achieved. In this context, it is important to focus on the development of human resources because the development of a more equitable, accessible and effective health service depends largely on people who are capable and willing to run such a service and also because a large part of any health budget is spent on the training and salaries of personnel, and inefficient use of human resources will result in considerable wastage.

The existing situation

The only available figures of health workers are from the professional registers. A brief look at the numbers of trained health workers in South Africa - approximately 187 500 in 1988 - indicates a relatively rich resource of skilled people. (This figure includes doctors, all categories of nurses, pharmacists, physiotherapists and assistant and supplementary physios, occupational therapists and assistants, psychologists and social workers.)

It is important to note that the professional registers exclude personnel numbers in the TBVC homelands and contain large numbers of health workers who are not practicing their professions or who work part-time. Therefore, the use of these registers as guidelines for human resource planning has been questioned. Nevertheless, on the surface it appears that a post-apartheid health ministry would inherit a favourable situation with regards to the numbers of trained health care personnel.

A number of serious problems, however, exist in the current policies, training, use and management of health workers.

Problems

1. Lack of national health personnel plans and policies for the training, deployment and management of health personnel

The lack of national planning has resulted in personnel development failing to match the health needs of the country:

- training institutions are linked to tertiary hospitals and don't take health care needs of the majority into account.
- no co-ordination between educators and health services as employers of the "graduates".
- fragmentation into different health departments makes coordinated planning and the assessment of health personnel needs difficult. Also, the reallocation of personnel along rational and equitable lines becomes almost impossible. As such, there is no consensus nationally on the relationship between who should provide what kind of care and the resources available for health.
- there are no incentives, career opportunities or regulatory mechanisms ensuring a shift of personnel to less privileged areas.

2. A maldistribution of health workers

It is well known that the deprived areas of South Africa and most areas worldwide (rural and periurban) have considerably lower health worker: population ratio than the more affluent urban areas. In addition, the distribution of health worker to population ratios differ between black and whites.

The problem of maldistribution is compounded by the largely unregulated fee-for-service private health sector which consumes nearly half of the gross health expenditure while serving only 20% of the population.

3. Health workers in the private sector

A large proportion of the country's health personnel (particularly doctors) have become accustomed to a lucrative system of private practice. The private sector has attracted many health workers (par-

ticularly nurses) who are dissatisfied with the working conditions in the public sector.

There will undoubtedly be major resistance to change from the health personnel active in the private sector, who may be concerned about their income levels in a future national health service.

4. Inappropriate training of health personnel

Training is individualistic, curative orientated, with a high reliance on technology. This preparation bears little relation to the challenges faced in the real working situation. For example, nurses are the major providers of primary health care in rural areas, yet their training is hospital-based, curative in orientation and dependent on supervision by doctors.

Professional education also has a strong "hidden" curriculum which creates health workers with attitudes of elitism, domination and control towards individuals and communities - attitudes which are clearly detrimental to the development of comprehensive primary health care.

5. Management of personnel

The current shortage of nurses has been well publicised in the media. Morale in the nursing profession is generally low. This relates directly to working conditions: low salaries, unsociable hours, a rigid hierarchy, little autonomy, poor support structures, sexist practices, poor housing and lack of career mobility and the lack of strong bargaining structures for nurses.

The failure to retain nurses in the public sector has serious implications for a future health service. In addition, a frustrated and burnt out work force does not provide creative, quality care. A discontented, disillusioned workforce will ultimately lead to national health services losing their competitiveness as employers. (Simmonds; 1988)

The majority of present health service managers are politically and professionally conservative. This is compounded by a scarcity of health personnel with suitable managerial and leadership skills.

A. Problems with teamwork

There is little coordination between the separate management structures for nursing and medical staff with top management structures usually reserved for doctors. There are also barriers created by nursing towards other categories of health workers.

The inequalities between nurses and doctors (salaries, power, status and perceived value of work) has given rise to conflict which has until recently been largely ignored and has serious implications for teamwork in PHC.

B. Use of personnel

Much of the health care being provided (particularly in more affluent areas) could be provided by lesser trained people. For example a paediatrician may be consulted for a problem that a mid-level health worker could deal with adequately; normal deliveries performed by obstetricians instead of midwives and so on.

6. The vested interests and power of the professionals

Professionals, particularly doctors are unlikely to relinquish both their political and economic power and status.

Attempts at curriculum reform in medical education has been met with strong resistance from some faculties.

Nursing has been preoccupied with its professional status and will resist changing the curriculum to suit the needs of the communities. As may occur with doctors, the introduction of auxilliaries may also be seen as a threat to their status.

The South African Nursing Association (SANA) and the Medical Association of South Africa (MASA) are likely to resist change and the lack of a strong democratic nursing organisation poses a serious obstacle to change.

Accordingly, care needs to be taken and strategies worked out, not to provoke a crippling resistance to change among those who will actually be implementing new policies.

7. Communities' expectations of health care providers

A wealthy community will not readily accept having to see a Primary Health Care Nurse (PHCN) before a doctor, or even a general practitioner before a specialist. The fact that they may be more articulate in these demands may result in dual standards - village health workers for the deprived rural villages and physicians for affluent urban communities. The problem is compounded by health not being adequately debated on the political agenda in the same way, for example, that education is.

In summary, these are some of the problems which we will face in the process of trying to build a new health service. Realistically, the result is likely to be less than perfect owing to the necessity of mediating the needs of different groups all wanting a particular approach.

Prerequisites for personnel policies to be successful

To achieve a situation of equitable, efficient and effective use of health personnel in this country, the minimum needed would be:

- a political and economic commitment to these principles in the health sector and other social services;
- a process of national coordination in one central structure which:
  - integrates the functions of policy making around personnel (planning, training, deployment, management and evaluation) with policy making in health care generally;
  - is based on non-racialism, democratic participation and the primary health care approach;
  - seeks to be relevant and appropriate to the needs of the communities served;
  - is in line with the economic resources available for health.

Ideas for debate

1. Research and formulation of key policy issues

As a first step, an assessment of health

needs and the availability of economic resources for human resource development in health is needed. As part of this process, there should be wide consultation with communities, the relevant organisations and interest groups involved. Based on this, policies can be determined concerning the types and roles of health workers needed, the training required, the numbers needed and how they need to be distributed.

2. Who should provide PHC ?

Questions that need discussion and debate are whether Community Health Workers (CHW) should be part of the PHC team; to what extent should a cadre of health worker other than a medical practitioner be responsible for providing comprehensive, essential, first contact clinical care. Experiences from countries using other cadres of health workers would be useful for us to learn from.

The appropriate members of the primary health care team should be decided upon, and questions such as whether the health service should be predominantly doctor, nurse or Village Health Worker centred, and how a situation of equality between rural and urban, between rich and poor areas is going to be established, must be answered.

Also needed are structures for the establishment of accountability by health workers towards communities at a local authority level, as well as at a regional and national level.

Progressive groups should then adopt these policies as a united front. Ultimately, the above should result in a coherent national personnel policy which aims to ensure the even distribution of health personnel within the framework of a national health plan.

3. Training of health workers

Principles for training should be: community based and supportive; relevant to health needs and future role; problem orientated and based on progressive adult education principles and should include a PHC orientation.

Certain aspects of education should be multi- and interdisciplinary and should stress aspects of teamwork. Education should also stress accountability to communities.

A national continuing education system should be developed which is implemented regionally and locally and which develops primary health care.

4. Exploration of progressive management systems

The concept of team work should be encouraged. There should be maximum delegation of responsibility and decision making to the health worker teams; equal participation by all in the team; clear role definition, with the leader not necessarily being the doctor or nurse. At the same time the problems of teamwork in primary health care needs to be explored, lessons learnt from the experience of other countries and research needs to be done on managing people in a progressive way.

There is obviously the need for proper working conditions and adequate career structures. There should be incentives for work in unpopular areas, adequate remuneration and clear role definition.

There is a need for a reduction in the salary differentials between different categories of health workers and for strong bargaining structures for health workers, especially nurses.

4. Strengthen progressive organisations

There should be an all out attempt to organise nurses, doctors and other health workers to counter the control of SANA and MASA using a clear programme of action.

At the same time, we should attempt to deepen the contradictions within state and state supportive bodies and perhaps the question of strategic alliances with those who are critical needs to be explored.

5. Lessons from existing experiences in South Africa

There are interesting experiments occurring in the field of human resource development in South Africa. For example, PHCN training and continuing education, village health workers and community rehabilitation worker programmes. They generally function on a small scale, in the face of considerable obstacles. These should be studied more closely to see if they could be generalised to the country as a whole. ❑

ANC experiences in health personnel development

by Manto Tshabalala, ANC

Major issues in the development of health human resources revolve around questions of production and utilisation to ensure availability and accessibility of health care.

ANC policy

Consideration in the production and utilisation of health workers includes:

- ☆ acceptance of health as a basic human right;
- ☆ political commitment to health for all;
- ☆ the need to redress existing inequalities in health status and the inequitable distribution of human resources;
- ☆ co-ordination amongst all sectors in the movement (ANC) to support the health development programmes;
- ☆ community participation as an essential component in planning and implementation of health development programmes.

Because development of health personnel is located within the accepted context of primary health care, it focuses on the principle of equity, which has a moral value. After all, the future democratic government will be guided by the direction and the pace it adopts to redress the centuries of oppression and exploitation and also in the area of the provision of health care.

The development of health human resources in the ANC has, therefore, had to:

- clearly conceptualise an integrated development of health human resources;
- satisfy the requirements of the human resources both in terms of quantity and quality;
- ensure relevance and professional competence;
- guarantee proper development and efficient utilisation.

Communities

The ANC Department of Health was called upon to deliver health care to:-

- the members of Umkhonto we Sizwe who require special attention because of the type of special tasks they perform in the drive to liberate our motherland.
- the school children, who have been brutalised by the repressive and the oppressive system of apartheid;
- young, and in most cases, single mothers and their children;
- after almost 30 years of exile life, elderly people with chronic diseases such as diabetes and hypertension;
- difficulties of aclimatising to new exile living conditions have manifested themselves in mental health problems, including, amongst others, severe depression, alcoholism and drug abuse;
- diseases that are a product of racial discrimination, oppression, depression, poverty and underdevelopment are often prevalent amongst refugees from South Africa, for instance, a high incidence of tuberculosis;
- tropical diseases that are not prevalent in South Africa - malaria being the most devastating;
- recently, incidents of HIV infection and AIDS.

The ANC Health Department

In the early 1960s, members of the ANC were treated mainly by medical auxillaries, who had been trained on the job. They were referred to as "Medical Officers". Their training met the criterion of competence as it was problem-oriented. The main problem was malaria. There has been no registered death of malaria during a period of over 15 years, despite malaria being unknown to both patients and providers of health care.

Because health is a basic human right for all the ANC cadres, it is free. It is, as far as possible, made easily available and accessible. As a matter of principle, health care is also free for the local population in the neighbourhood of the refugee settlements. This therefore puts a great demand on the numbers of the health care workers.

Initially, health care was curative and institution-based. Elements of prevention and community-orientation were introduced with time. Rehabilitation, especially counselling, remains a problem in a situation of an acute shortage of trained personnel with appropriate skills. At times this becomes inadequate where communication and proper understanding of the aetiology is problematic.

With the exodus of thousands of the youth, particularly following the 1976 Soweto uprisings, it became imperative

to set up a health structure that was to provide comprehensive health care; disseminate information on the effects of apartheid on health to isolate the apartheid regime in line with the economic, cultural and academic sanctions; formulate health policies for our communities; organise material and moral support for the Movement and also identify areas for training health personnel.

A Medical Committee set up on 5 August 1977 soon expanded to a Department of Health to which all health workers belong and can be elected to any position irrespective of their field of training. This has had its problems in terms of intraprofessional working relationships and representation on international bodies. The Department of Health has a Secretariat, whose members are the Secretary for Health, the Deputy, Officers in charge of Community Health Programmes, Logistics and Supplies, Information and Publicity, Personnel Development and Deployment.

Each region has a health team that is represented and works in close collaboration with other sectors of the Movement including the regional political structures. Because the head of the Department is not a member of the National Executive Committee, some health recommendations take a while before they are actually adopted as policy.

To date the ANC has trained an army of health workers including doctors, nurses, dentists, laboratory technicians, medical assistants and more recently - social workers, whose work used to be performed by political commissars and health workers.

There has been a deliberate move to encourage people to specialise in areas of public health and administration including health planning. Lately some doctors have been encouraged to specialise in conventional areas such as gynaecology, paediatrics, psychiatry and internal medicine. Nurses have tended to specialise in health education.

In order to get a sense of managerial processes, the Department of Health has held a number of workshops on management, essential drugs, mental health, maternal child health, primary health care and many other topics. These workshops have been organised on an intersectoral approach, with members of other departments and sectors invited to participate, in order to acquaint them with health development approaches.

Joint initiatives were undertaken with SWAPO of Namibia in training health workers and also in running courses that prepared students for entry into health institutions.

Constraints and obstacles

Generally, the ANC relies on the international community for material and financial support in order to implement its programmes. Sometimes neither finances nor facilities are available. In a situation where one does not always have an indicative planning figure, serious difficulties have been encountered in trying to synchronise development with the overall plans.

Conflicts and differences of opinion between the health planners, other interested groups, professionals and even the communities who are consumers of health care, have arisen in determining the category of health worker to be trained, especially with regard to medical assistants. This is a new category of health worker, within the health profession in South Africa.

Medical assistants, together with the medical auxillaries and those trained on the job, have been the backbone of health care delivery in the settlements. It is necessary to study and understand clearly their curriculum in order to avoid time consuming, sometimes painful processes of negotiations and compromises in personnel choices. The guiding principles often have to be equity and competence.

The management of these resources can be extremely complex. The complexity is compounded by the fact that this sector is composed of people with various levels and categories of training, various attitudes, motivations and work patterns. Noticeable are the strong preferences for deployment in the settlements which are not far from the nearest town. This has often led to a maldistribution of personnel. Those in the settlements that can be referred to as "hardship working areas" remain there for extended periods of time. Motivation of course is bound to drop and this raises the question of incentives. Financial incentives are not always easy to provide. The improvement of working conditions requires both political commitment and financial resources. Sometimes the demands and expectations of communities in the settlements far outstrip the capacity of the health workers and this can make the working environment very difficult. The basic necessities are, of course, provided by the Movement. These include creches and day care centres for all, including the health workers.

Career mobility, including further training becomes the only meaningful outlet where political persuasion on commitment and improvement of attitudes fails. This is understandable. After all the Soweto uprisings were, amongst other things, around issues and struggles for education. The impatience of some health workers against the delays in obtaining placement in institutions in order to improve their level of education and also improve their skills, is therefore tolerable.

Not all the trained personnel make themselves available on a fulltime basis for service in the settlements. Even the policy of a minimum of two years deployment in the settlements has not been readily accepted by some workers. Most of them have taken up employment with the Ministries of Health, mainly in the Frontline States. Indeed, the Movement has had to make arrangements for them to be employed on local terms. And so they continue to improve their skills in preparation for returning home. While they do not work directly with the Movement, they contribute from time to time by seeing patients referred by the ANC to the hospitals. They are also part of regional structures and units.

For fulltime functionaries, this means an incredible load of work, at times with great sacrifices. There is hardly an opportunity for holidays and such workers are often unable to take upgrading courses and specialisation. In most cases, this burden falls on those who are highly politically motivated.

Some nurses have preferred to do medical training rather than develop in the nursing field. This has meant six-

seven years of training. The fact that opportunities for medical training were not easily available in South Africa, could be one of the reasons for their choices.

The question of who leads and heads the health team has often arisen as most of the nurses have long years of experience in comparison with the young qualifying doctors and medical assistants. Gender issues have been manifested in the intraprofessional health struggles, even within the Movement.

A difficult component of planning involves the implementation of supervision. Senior and experienced health workers are overstretched. Sometimes, travelling in order to supervise health workers on the ground is misinterpreted as legitimised truancy and yet these visits are usually appreciated by the health workers. Where the health workers do not have adequate skills, supervision is the key to success and continuing education.

Planning has tended to focus on numbers rather than quality issues. The evaluation of the performance of health workers, which has not always been comprehensive, clearly demonstrates the need to properly manage all the levels of primary health care to ensure quality of care and comprehensive care.

Managing volunteers has not been an easy task. They have dual accountability. Procedures of integrating their expertise to the local experience is not easily accomplished.

The role of traditional healing has been highly debated amongst health workers. Some are ready to work with traditional healers, while others believe the tragedies arising from this service are too horrifying to even begin to isolate the positive aspects involved.

By and large, the experiences of managing health personnel within the liberation movement does not differ much from management by Ministries of Health. What has been gratifying is the commitment of those health workers who left for upgrading and have come back to their communities and settlements more dedicated than ever before to continue their work. It surely should not create problems to integrate the health workers trained by the Movement into the people's health care system of a future democratic South Africa. We hope this conference can lay the basis for mechanisms and guidelines of integrating them. ❑

PERSONNEL CHOICES - AN OVERVIEW

The objective of this section of the conference was to look at the kind of personnel development necessary to achieve an equitable, accessible health service in South Africa. The first two papers outlined the current health personnel available and, given the limited financial resources available, initiated debate around the most appropriate category of health worker to be trained as a priority. One of the crucial issues to be addressed in the implementation of a national health service is which categories of health worker should deliver primary health care. Internationally, experiences have ranged between minimally trained Community Health Workers (CHW), mid-level health workers such as nurses and medical assistants and medical practitioners. Arguments for and against the various options were presented.

The lack of a coherent national policy on personnel development was partly to blame for the current irrational training and distribution of personnel and the obstacles to achieving change in this area were examined. Debate around these two articles resulted in the following proposals:

■ There was a general feeling that the most appropriate first tier of PHC worker would be the Community Health Worker (CHW) but the delegates acknowledged that the debate was still in its very formative stages.

CHWs should be elected by and be responsible to the community in which they live and their training should, as far as possible, take place in this community. They would deal with minor illnesses and play a key role in prevention and health education. They would refer difficult patients or patients needing more specialised care to the Community Health Centre which would be staffed by both mid-level health workers and doctors. Lessons can be learnt from the experiences of other countries, particularly with regard to problems with large national CHW programmes.

CHWs would have peer group supervision with the possibility of career mobility within this category (e.g. to supervisor of other CHWs and on to regional supervisors). They should be well trained to avoid "dual" standards (see previous papers), and their work should be paid for.

■ The Community Health Centre will be responsible to the community it serves. The community will in some way be able to influence services and policies of the centre. Above these centres would be regional and teaching hospitals, but the emphasis would be on primary health care.

■ Mid-level workers - it is important to work out one category of mid-level worker. Whether a decision in taken in favour of PHCNs or medical assistants, it is important that their training be relevant from the beginning of their courses.

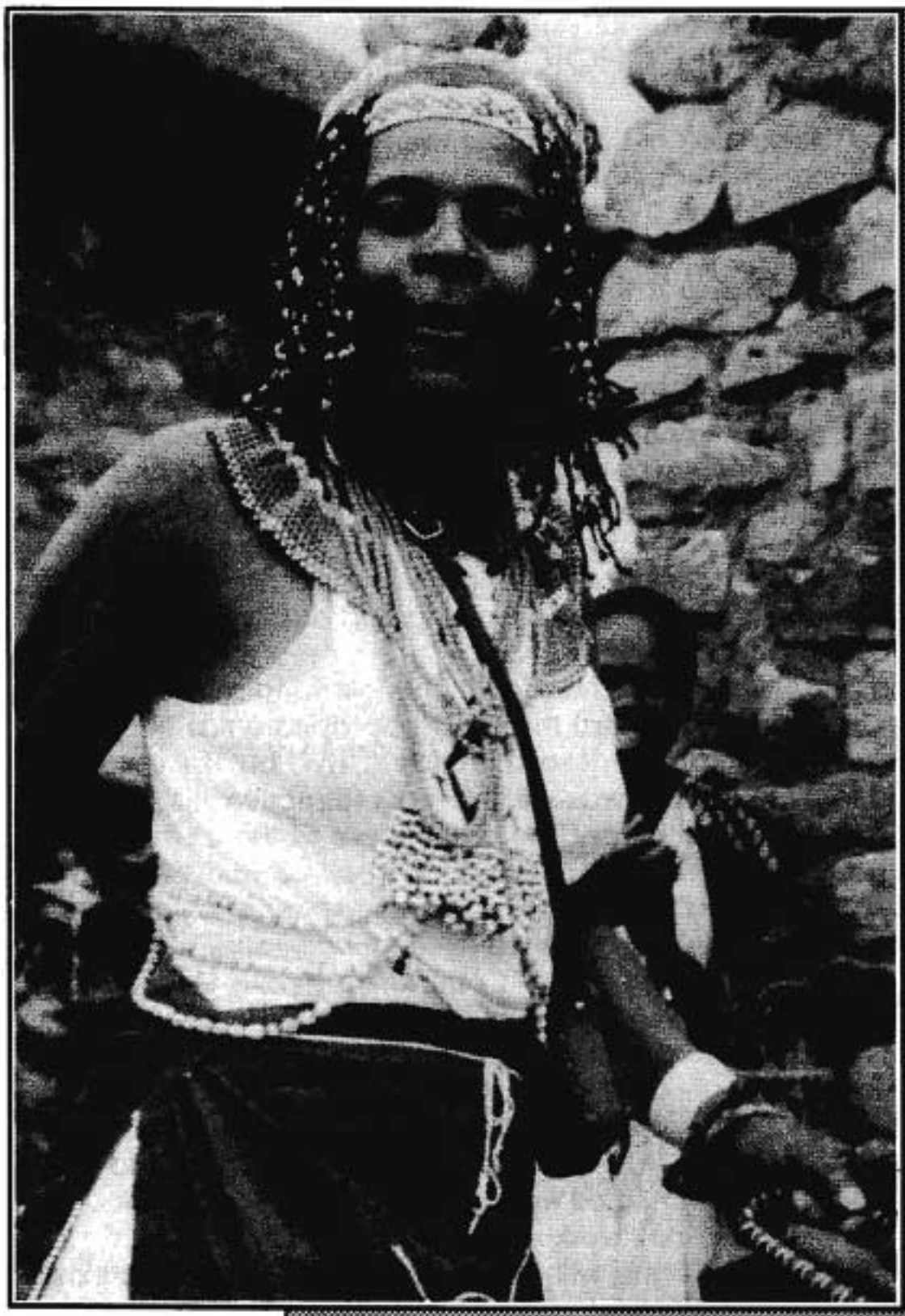
■ Training of all health workers should be community-based, problem-oriented and should inculcate a primary health care vision.

Manto Tshabalala of the ANC delivered a paper outlining health personnel development within the organisation as well as the problems the Movement has faced in this regard.

Over 100 ANC doctors have been trained while in exile and an emphasis has been placed on the training of medical assistants. She stressed the need to incorporate such personnel into the health sector when they return from exile. The need for career mobility for these health workers was also stressed.

Dr Boat from the World Health Organisation (WHO) presented a paper suggesting principles and problems involved in the planning of human resources in the health sector. The following steps were recommended as an approach:-

- Analyse current trends in the health sector;
- Analyse human resources available;
- Estimate future supply of staff and compare with estimations of the future demand;
- Identify imbalances between supply and demand and generate solutions;
- Select strategies for the development of health personnel and elaborate a plan of action for their implementation to include the meeting of short, medium and long-term objectives;



The function of traditional healers should be recognised as a social reality and their role in a future health and welfare service needs to be researched.

ill Budget for all of the above.

These steps should be taken in the context of a national health policy and bearing in mind political, socio-economic and environmental constraints.

Melvyn Freeman presented a paper on the viability of traditional healers as health care resources. He outlined the various options for integrating such healers given their large numbers and the integral role they play in many South African communities. The arguments against their inclusion were also presented, from "opponents" as well as from the traditional healers themselves. The paper emphasised the importance of addressing this issue.

Sisa Njikelana of the National Education, Health and Allied Workers Union (NEHAWU) spoke about the challenges of industrial relations in the health sector. He stressed that the apartheid-capitalism state intervention in health care delivery has compelled unions to go beyond conditions of employment to address issues such as the financing and control of health services as well as to relate workplace issues with the political economy of health. He outlined the poor conditions under which many health workers are employed and pointed to the success of industrial action undertaken by such workers in convincing the authorities that the unions cannot be ignored. Union and management strategies are also changing in response to the emergence of new conditions in both the health sector and the broad political arena.

Future prospects for industrial relations in the health sector will be influenced by issues such as further political and economic changes in a pre and post apartheid South Africa, privatisation trends, future moves towards a national health service and trends in the distribution of resources, the extent of unionisation (particularly of nurses), labour legislation, the role of the ANC, developments in the current unity talks between the various progressive health organisations and the actions they undertake, the deprofessionalisation of health personnel as well as democratisation and control of health institutions.

He stressed the importance of union participation in policy formation and the central role the workers will play in safeguarding working people's interests in the post-apartheid state. The recent success of union protests in areas such as privatisation demonstrates the potential of organised workers to win and implement policy changes.

THE WAY FORWARD

1. ANC health personnel must be integrated into South African health sector. Special concern must be given to the integration of medical assistants and the ANC should collect information on the curricula studied by these health workers in order to facilitate this process. Progressive organisations internally should set up groups to negotiate the registration of ANC health personnel with the appropriate bodies before these exiles return.
2. Research is needed into existing CHW programmes internally and internationally to assist in personnel planning.
3. The role and function of traditional healers should be recognised as a social reality. Extensive research is needed into areas such as the kind of problems they are working with, what networks could be established, how these healers are organised, etc in order for a policy to be developed on this issue.
4. The issue of disunity amongst health worker organisations/unions must be urgently addressed.
5. A strong united front is needed in relation to privatisation.
6. Professionals have too much say in health care and unions must be involved in the formulation of health policy.

Special issues

- Women
- Occupational health
- Returnees
- Family and child health

Women

Women's issues are sadly low down on the political agenda of most progressive organisations, and health is no exception to this. In a conference that lasted one week, 2 hours of the last session of the last day were devoted to women's health. Even then the women's health workshop was run parallel with 3 other workshops. This meant that only 30 women and 6 men attended the session, and they in turn attended one of 3 parallel discussions: maternal and child health, women and mental health, and reproductive rights (contraception, abortion, sterilisation) with sexually transmitted diseases.

A major theme to come out of all these workshops was that women's issues had been marginalised at the conference, and that affirmative action must be taken on women's issues in the future. Any debate or decision on health policy must ask the question "How does this affect women?". This positive approach towards women is not intended to exclude men, but rather to include them in the debate without allowing them to take over. It was agreed upon that women should have significant central positions on political structures and not just on a token basis. More particularly, the benefits versus risks of having a women's ministry was raised.

The discussion on women's mental health was dominated by the urgent need to deal with the effects of the war in Natal on women and children. As a longer term strategy, the importance of educating both the community, political activists and primary health care workers on the relationship between emotional and physical health was stressed, and the need for permanent support systems such as safe houses for battered women was suggested.

Any real headway with reproductive rights will only be made if there is a fundamental change in the relationship between men and women.

The discussion on contraception did not focus on the advantages and disadvantages of the various methods, but rather on the rights of a woman to give informed consent based on adequate health education. The same applied to the question of sterilisation. On the question of abortion policy the group unanimously recommended that abortion should be available on demand, backed by comprehensive abortion counselling services. The definition of exactly what everyone meant by "abortion on demand" was not discussed.

The Maternal and Child health group spent the first part of their discussion looking at the problems with the current definition of maternal health. Maternal health in this context tends to focus on the woman merely as a vehicle of child bearing, rather than on the woman at all ages and in all states of fertility. This broader definition of maternal and child health was accepted, but it was also noted that there was no section looking at children's health in the conference. Much of the remaining discussion concentrated on UNICEF's proposal to come to South Africa after change has come, and to introduce their child health survival strategies here. Participants from the Frontline States cautioned us that although UNICEF has many good things to offer, there are many drawbacks to the way they operate. Their strategy is implemented without consultation with progressive health structures working in the field, nor with women of the country themselves.

It was noted that urgent research need to be done inside the country into what would be a suitable maternal and child health strategy, and this should be complimented by external research looking at UNICEF's role in the Frontline States.❑

Returnees

This workshop concentrated on the issue of returnees. Two papers were given, the first by P.Naiker of the ANC, the second by L. Floyd of the Detainees Service. The papers and discussion reflected the areas outlined below.

A Repatriation Committee has been set up by the ANC and will communicate with the structures within South Africa. Approximately 18-20 000 returnees will need direct assistance (excluding Umkhonto We Sizwe cadres and those in self-exile) although many exiles are self-sufficient and will not need direct material aid. Part of the preparation for returnees must involve the integration and registration of ANC health personnel.

Psychosocial, medical and rehabilitative support will be needed. Exile has often resulted in anxiety and depression particularly felt by those who experienced torture while in South Africa.

Orphans of cadres who have died have to be taken care of. (The ANC needs to collate concrete figures to help preparations.)

As far as possible children should be placed with relatives, friends or foster families, with institutionalisation being the last option. Counselling and support will be needed for the children and the families they live with. Payment of foster parents (by the state or the ANC and community organisations) needs to be addressed. The tracing of families will be one of the problems to be faced.

Some cadres have married people from the countries of exile and those families must be accommodated. Many who grew up in exile speak foreign languages and special courses may be needed to assist them in learning English.

Teenage pregnancies and substance abuse also need to be dealt with as does care for those cadres disabled during action.

Employment, housing and general social support as well as care for the aged will be needed. Certain qualified cadres may need additional training to work in South Africa. This should be looked into.

ANC cadres were only tested for HIV when entering countries that required this. However, the issue of AIDS in relation to returnees needs to be highlighted in order to dispel the myths that have been established around this issue.

The returning ANC community must be incorporated into the existing mass organisations down to the level of street committees.

A national reception committee must be formed by the ANC in consultation with the MDM, the Church and existing civic and welfare structures. Community organisations and those with experience in the field of counselling and working with political prisoners should be involved.

The issue of funding must be addressed. Money is needed for the staffing and running of the Reception Centres. Present services within the community must be utilised and the option of using state services must be decided upon. A breakdown of areas to which returnees will be going must be provided.

The workshop agreed that all returnees, irrespective of their political affiliation, should be serviced by one co-ordinating committee and recommended that organisations take up the issue of returnees urgently with their constituencies to ensure that organisations provide specialised services in accordance with anticipated health and welfare problems and that they work through and in conjunction with existing local reception committees. ❑

Many rural families have been divided through the system of migrant labour. The importance of children and family life must be stressed, both in rural and urban areas.

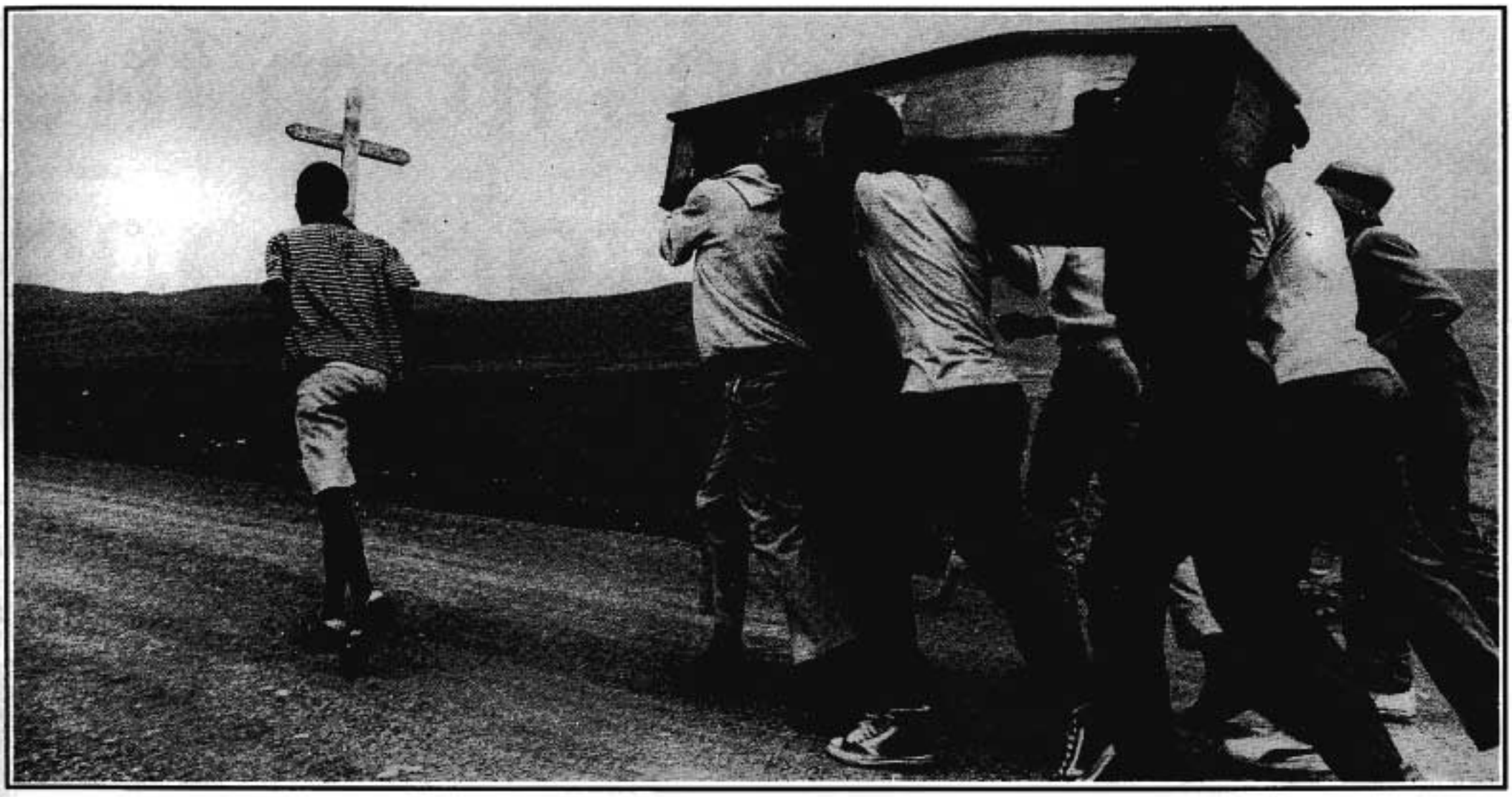
Children and family

The workshop was attended by about 9 people representing mainly the welfare sector. The group was fortunate to have as one of the participants Ms Graca Machel, who shared important developments that had occurred in Mozambique in response to the needs of children.

The objectives of the workshop were:-
1. To identify issues and elements that a future welfare policy should contain.
2. To discuss the basis for promoting a children's rights campaign.
3. To develop strategies for meeting the needs of children.
4. To identify areas in which these rights were being violated.

The workshop's deliberations were facilitated by the paper, *Towards a Child and Family Policy*, by Ms M. Naidoo. Her paper highlighted the various deficiencies with the existing legislation as well as the various forms of abuse that children experience and the need to develop a child and family policy for a future South Africa as well as during the transitional phase.

Discussion began by expressing concern about the plight of children under repression and more specifically the Natal situation. This issue needed to be urgently addressed at a national level and various sectors of our community need to



Comrades bury two youths allegedly abducted and killed by Inkatha vigilantes - welfare will need to work together with other sectors to assist the thousands of people affected by the violence in Natal.

be mobilised on this issue.

Specific strategies that emerged were:

In the short term

1. Link up with Women's organisations and UNICEF to jointly take up the issue.
2. Recognise that welfare needs to link up with other sectors to respond to the problem of dislocated children from the Natal violence.

In the medium term

Accept that we do not live in a normal society and we need to develop a policy which takes this into account.

In the long term

Formulate a policy for children and families on the basis of a non-racial South Africa, based on principles of equity, appropriateness and community participation.

How to achieve this

1. Use any available platform to stress the importance of child and family life.
2. Put children and families on the agenda of progressive organisations.
3. Ensure that relevant research is undertaken.
4. Evaluate and assess the effectiveness of current interventions in order to plan future programmes. ❑

Occupational Health

The workshop was attended by around 30 delegates. Papers were presented covering general aspects of occupational health including international health and safety standards; specific initiatives taken by trade unions in South Africa and their implications for the debate on a national health service, and for the types of research that are required; and a FAWU representative presented the experience of the FAWU workers' clinic in Paarl. This paper demonstrated how a clinical facility can function under union control. The need to link environmental health concerns to occupational health and welfare activities was also discussed.

The workshop recommended that participants should pursue the goal of an occupational and environmental health and welfare service as an integral part of the future national health service. Such a service should be responsive to community and trade union organisations, involving them as participants in the provision of the service and in defining research agendas.

The specific suggestions made by the workshop were:

☆ Health workers' unions can campaign for better working conditions for their members and address the question of health, safety and welfare at work.

☆ Professional and campaigning bodies involving health workers can look for ways to assist campaigns on health, safety and welfare at work and in the environment which are carried out by trade unions and community organisations.

☆ Delegates can look for ways to initiate research into existing occupational and environmental health and welfare resources to assess them in the light of the goal already mentioned, and how these can be transformed in keeping with the general principles endorsed by the conference on a national health service.

They can also carry out research into what types of training would be necessary. This would include both professional persons and people outside the professions (including trade union and community representatives). The results of this research should be made available to all progressive health workers' organisations, the trade union movement, and relevant community organisation, and should be fed into debate within progressive organisations around the question of the future national health service. ❑

Lessons from the Frontline States and the UK

Representatives from the Ministries of Health of the following Frontline States shared their experiences with the delegates: Namibia, Mozambique, Angola and Zimbabwe. All these countries inherited some common features in their health systems post independence. This included a discriminatory health system based on racial, economic and geographic grounds, and one which had little or no preventive aspects.

Some of the common problems faced the incumbent governments were:

- The loss of skilled personnel: this was a major drain on the country's resources, often crippling the health services, and was difficult to replace in most instances. The loss was either to other countries or to the private sector and was a result of ideological or economic reasons.
- The dominance of the private sector, which served to undermine the public sector. This was an important power base in society and was not always easy to challenge.
- The emphasis on urban-based curative health care.
- The effect of destabilising reactionary groups on the health services and economy. This was most clearly seen in Renamo's destabilising effect on Mozambique.

In order to redress some of the historical imbalances and maintain a cost-effective health service, certain recommendations were made. These included:

- having an accurate assessment of the country's health and welfare status at the point of transition. This would be invaluable in planning any future health service;
- giving priority to rural areas;
- emphasising preventive and promotive health, whilst recognising the need for tertiary care;
- creating a national health service (NHS);
- training of health personnel e.g. village health workers, medical auxiliaries. This would be cheaper than training doctors and should be designed to meet the health demands;
- legislating state intervention into the private sector in order to serve the needs of the people;
- the formulation of an essential drugs list for the NHS, and possibly a non-essential drugs list for the private sector;
- compulsory community service for all graduates. This would help to keep newly-trained staff in the public sector and to serve the underdeveloped areas. Preparation for this would have to be attended to in the curriculum and training;
- a political commitment to primary health care;
- mass campaigns for health education;
- a system of referral from the health post to the provincial hospital to the teaching hospital;
- the incorporation of allied sectors into the health care delivery system e.g. the church, traditional healers, mining companies;
- adopting a multidisciplinary approach to diseases.

From this session it became apparent that there are many lessons to be learnt from our colleagues in the Frontline States. ❑

Experiences from the UK have shown that health services as such are not the major determinants of good health. A lack of knowledge of available services, language problems, insensitivity to cultural values and child care problems, as well as a host of other obstacles, inhibit free access to health services even when they are available.

Lessons from the UK

The National Health Service (NHS) in the United Kingdom united both a fragmented and unequal health system, since its establishment by the Labour Government in 1948.

The services are free at the point of delivery, available to all and provide a high standard and uniform level of health care for the rich and poor alike.

The funding of the NHS predominantly from general taxation is part of a political commitment to an NHS. Originally the intention was to finance it largely from a national insurance system, with contributions taken from wages of employees and supported by contributions from employers - the system covering employees for both health and welfare benefits. In practice, however, this makes up only about 10% of NHS funding.

Academics and doctors were the major obstacle in setting up the NHS. Support for the NHS was rewarded with financial merit awards, in addition to their salaries, in exchange for not undertaking private practice. This approach, though not politically ideal, worked in terms of limiting private practice.

General practitioners play a referral role, are paid a flat fee based on patient list sizes and a fee for service component based on preventive activities.

Consultants have clinical autonomy and a job for life. They engage in some private practice but rely on their NHS posts for patient referrals. This is problematic in many ways but ensures the consultants remain within the NHS.

Positive aspects

- National planning and rational decision-making over the provision of facilities and the planning of personnel has reduced duplication of expensive high-tech services, established appropriately located facilities, introduced primary health care workers and established a national drug policy and an essential drugs list.
- Although underfunded, the NHS has proven to be cost efficient and to provide a high standard of health care for all through the referral system. Only 6% of total funds goes towards administration.
- Staff support - even in the recent attacks on the NHS, staff from all political persuasions have been united in their support for the NHS.

Staff morale is essential. Real problems such as poor wages and working conditions must be addressed.

Problems

- The power of doctors.
- The power of consultants to freely introduce new, often unevaluated technology, leading to soaring costs.
- Hospital-based care dominates over preventive care.
- Access to services is not necessarily made equal by establishing a free and available service. Lack of knowledge about available services, language problems, insensitivity to cultural values, all inhibit free access. Also, certain groups such as women need to have their specific needs addressed.
- Lack of community participation: attempts at community participation were made through the Community Health Council (CHC) structure. These are made up of nominated community members as well as fulltime workers. Legally, the CHC must be consulted about plans of a district health authority, for example, a decision to close a hospital. In practice, however, they only have the power to delay and refer back patients.

A further attempt at community participation was made through the District Health Authorities. They have a trade union and an education representative as well as local authority representatives on them. In practice, however, this does not work as real community participation - the lack of which has helped facilitate political manipulation of the NHS as we have seen in the UK recently. ❑

HIV and AIDS in Southern Africa

Draft Maputo Statement

Introduction

This statement was prepared and agreed to by delegates at an International Conference on Health in Southern Africa held in Maputo, Mozambique in April 1990.

The conference acknowledged research which shows that human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) is an established epidemic in South Africa and throughout Southern Africa.

The magnitude of the epidemic is increasing rapidly within the Southern African region. Recent research has shown that nearly 60 000 people are thought to be infected in South Africa alone. The number of people affected by this disease is expected to double every eight and a half months.

Delegates at the conference agreed that if no significant intervention is made within the next few months, there would be little chance of avoiding its disastrous consequences.

It was noted that the South African state response has been totally inadequate. Lessons drawn from throughout the world have emphasised the crucial role representative organisations have to play in combatting this disease. These community-based organisations need to develop an appropriate strategy which will reach the mass of our people.

The conference therefore made the following recommendations as policy guidelines for developing programmes around AIDS and HIV infection:

An HIV campaign must have the following features:

- It must be nonstigmatising and avoid stereotyping individuals and groups.
- It must be founded upon community-based action. Political and other leadership must be involved.
- It must identify and address the social and political factors relating to the spread of the disease.

The political profile of HIV and AIDS must be raised

HIV/AIDS is a social disease and should not be approached in a narrow biomedical fashion. Economic, political and social factors are major determinants of the rate of development and extent of this epidemic.

Features of life in South Africa and Southern Africa facilitate its spread. Poverty, migrant labour, population relocation, homelessness, forced removals, unemployment, lack of education and poor housing play major parts in the development of this epidemic.

The health care system is fragmented and discriminatory. Little emphasis is placed on prevention and health promotion. Communities do not participate in promoting their health and health services.

The HIV campaign waged by the state has been grossly inadequate. Communities have not been involved, nor have representative organisations been consulted. Too few funds have been allocated to HIV prevention and the care of people with HIV disease. The media and education campaigns have promoted fear, stigmatisation and discrimination.

Political organisations must play a leading role

Any attempt to deal with the HIV epidemic must be situated within the broader struggle for sociopolitical change. This will provide a context for preventive work amongst the broad group of people most affected by HIV infection.

Progressive organisations should inform their membership of the magnitude and importance of HIV infection. They should examine, analyse and respond to HIV with the support of their membership.

We can start by involving senior progressive political leadership within and outside South Africa. The African National Congress has a major role to play in this regard. The involvement of political leaders will help overcome suspicion and mistrust created by the South African state. A high public profile will raise awareness and stimulate appropriate action.

We need to involve worker, youth, women's, religious, political and other community-based organisations at all levels of work on HIV infection and

AIDS. We should assist these organisations to recognise the importance of this epidemic. Wherever possible, committees to develop a response to the epidemic and related problems should be formed within organisations and communities.

Change in personal politics is required

The HIV epidemic has revealed inadequacies in how we relate to one another. Sexism, victim-blaming and racial stereotyping decrease our ability to deal effectively with HIV infection at a grassroots level. Discrimination against prostitutes, members of the gay community, injecting drug users and other marginalised groups should be overcome. Programmes to rectify these discriminatory forms of behaviour should be initiated as part of the response to HIV disease.

The rights of people with HIV disease, as with any other health condition, must be firmly recognised.

Demands of the South African state

The South African state has not displayed any genuine commitment to dealing with the problem facing the population. We need to develop a set of demands directed at the state so that it does not neglect its responsibilities. These will include:

a) undertaking a serious preventive programme for HIV infection in the country. Adequate resources must be provided. Free condoms should be supplied throughout the country.

b) committing itself to providing comprehensive preventive, promotive, counselling, support, hospital and community-based services.

c) making available material and other infrastructural resources to community-based organisations involved in HIV campaign work.

d) abolishing discriminatory, repressive and restrictive legislation such as that discriminating against gays, commercial sex workers and foreign migrant workers.

The progressive movement should be at the forefront of developing appropriate strategies and should demand the resources to achieve this. State resources are ours and should be used as such.

Developing a community-based approach

A multisectoral community-based approach is needed to effectively tackle HIV infection. Communities must have control over activities and resources. Representative structures must ensure accountability.

We must acknowledge the importance of working with the unorganised and identify ways of facilitating their involvement and representation.

Broad programmes need to be translated into local-level activity. Safer sexual practices and behaviour change must be encouraged. Condoms must be made widely available and local educational materials and mechanisms developed.

Workers must be protected

We acknowledge the work undertaken by the trade unions in identifying and tackling the work-related problems associated with HIV infection. These include such issues as discrimination, testing without consent, denying medical and other benefits, and the lack of facilities for conducting appropriate worker-controlled educational programmes around HIV infection in the workplace.

We need to provide whatever assistance is required by the trade union movement in campaigning for employers and the state to fulfill their social responsibility to workers and the community at large.

Health workers

Health workers have a responsibility to care for people with HIV disease in a caring and nondiscriminatory way.

Adequate protection against the risk of HIV and other infections should be provided at all worksites.

Appropriate structures should be formed

An AIDS Task Force should be established. This must coordinate and promote HIV and AIDS work nationally in the progressive movement. It should develop a programme for preventing this infection from spreading and ensure that appropriate services are put in place to provide care. It must demand resources from the state to achieve these goals. It will need to build on existing organisations and involve all AIDS interest groups. A democratic structure, including representatives of the progressive movement, must be formed within the Progressive Primary Health Care Network.

An interim committee set up at the conference has undertaken the following urgent programme of action:

a) to set up a mid-1990 national conference on HIV and AIDS at which the National AIDS Task Force will be elected.

b) to distribute this statement and consult with organisations about the development of an appropriate response to HIV and AIDS and the formation of a representative structure to take this forward.

c) to draw in progressive political and community-based leadership in order to gain their support and involvement in urgent action to prevent the further spread of HIV infection.

Evaluation

The state programme needs to be examined and monitored in an ongoing way. We should reveal the weaknesses of such a campaign and articulate demands and alternative structures which will more directly address the prevention of this epidemic.

Our programmes need to be carefully and scientifically evaluated at regular intervals and modified accordingly.

Conclusion

South Africa and the whole Southern African region is facing a crisis over the HIV epidemic. Urgent action must be initiated immediately. The state programme is fundamentally limited and flawed. An alternative progressive campaign with the support of political and other representative organisations must be set up immediately.

An AIDS Task Force is proposed to take this urgent programme forward. Realistic objectives must be set, based on grassroots participation. The sociopolitical context of this disease must be acknowledged in all programmes. Safer sex must be promoted to protect the health of the community. ❑

Maputo, April 1990.

Meeting with Mozambique's Minister of Health

Delegates from each of the participating organisations at the conference were fortunate to be granted an interview with the Minister of Health, Dr Leonardo Simao. We were impressed by the openness and obvious sincerity of Minister Simao, and by the fact that his perspectives were informed by a solid political insight.

The following is a composite report, taken from the numerous notes that the delegates made during the two-and-a-half hour meeting.

The Minister opened the session by extending a warm welcome to the delegation. He raised the two major problems his Ministry has been faced with: the war situation, and underdevelopment.

War and underdevelopment

The war has created the need for emergency programmes, and has made it almost impossible to work in the rural areas, where more than 900 of the health units have been destroyed or attacked by the RENAMO bandits. As a result the health services have expanded and been concentrated in the urban areas, to which vast numbers of the population have had to migrate. They have implemented a mass immunisation campaign in the provincial capitals to increase the level of vaccination to at least 80%. This level has been achieved in Maputo, where it is now rare to see cases of measles, polio, or neo-natal tetanus.

To respond to the problems of underdevelopment, the Ministry is committed to creating conditions for the development of alternative forms of health intervention. Approximately 70% of the population rely on traditional medicine. The Minister feels patients have a right to choose, and so they still allow for the development of different systems of health care because of the overriding need to reverse the patterns of disease.

Expanding the health and welfare services

To expand the health services in the country, they are providing the infrastructure for community health centres, and for all levels of personnel such as village health workers, nurses, social workers, pharmacists, public health administration officials and so on. They also recognise the need to train specialists to improve the quality of health care, increase their teaching capacity and increase and expand their capacity for research, so that their policy decisions are properly informed.

A particular field to improve was that of social welfare. The quantity and complexity of traumatised people is enormous. Children, adults, families and whole communities have been traumatised. Despite this, the Minister also recognised the problem of the bandits themselves - they too are victims and the South African Government is hardly likely to rehabilitate them at the end of the war, despite having backed and encouraged them. Mozambique is concerned whether the bandits will ever be able to resume a normal life - a high proportion are likely to become the criminals of a normal future society, but with a particular background that will make their rehabilitation much more difficult.

Optimism for the future

The Minister said that their health policy must be continually evolving - they recognise the need to be aware of what adaptations have to be made, for the changes can be rapid. He raised the importance of improving the living and working conditions of health workers, not only to ensure the best calibre of people in the health services, but also to keep them within the system. He is optimistic about the future: there is a high proportion of young, highly qualified people in the government. The Minister made the point that there is a saying that in Africa independence started in the

North, but true development will start in the South. He commented on the enthusiasm of their cadres, and informed us how much they valued the moral support of other countries, sometimes above material resources. This moral support gave them a real sense that their struggles and sacrifices are in a just cause for the whole region. Hence they really appreciated this conference, which he felt was helping all of us, as when relationships between people are strengthened, this helps to build a better understanding between countries. He offered Mozambique as a resource to us - their experiences can inform us in our own development, so we can learn both from their mistakes and successes. He warned, though, that we will still make mistakes!

The Minister stated that one way to avoid mistakes is to maintain a dialogue with the people. All personnel in the Ministry of Health have to spend some time in the Provinces: this keeps them in touch with reality, so they can keep a balance between technical solutions and clinical reality.

In response to a question about admissions to training programmes and in particular to Medical School, he replied that the problem was not a class one, but one of city/rural origin. Hence, built in to the system is a series of rural attachments during medical school, and thereafter. The Minister himself teaches at the Medical School, and is involved in the allocation of students to districts. An additional incentive is that if you want to specialise, you must work for at least 2 years in a rural setting, but for at least 4 years if you have worked in an urban one.

Social services

With reference to social services, the Minister described several programmes, with respect to children, disabled, elderly, the hospitalised and, for them, a new area of mental health. There are approximately 200 000 children who are removed from their parents. They have tried to place these children with relatives or with other families. They continually tried to encourage this by giving material assistance to individual families but they have found that a more effective strategy has been to give assistance to whole communities, by way of encouraging community programmes around the adoption of the displaced children.

Similarly, their programmes for the elderly are aimed at retaining their integration with family and community, so as to discourage institutionalisation. Because of the war, there are larger numbers of disabled and handicapped people, and last year a Handicap Association was formed. The project is aimed at dignifying the handicapped, and the development of self-reliance, for example by developing prostheses that can easily be repaired.

Mental health

The mental health programmes started only last year. They have adopted a multidisciplinary approach, involving social workers, psychiatrists and psychologists.

For the elderly, old-age homes were discouraged, so that the elderly can remain part of the family. They are encouraged to remain useful - for example a kindergarten was run by elderly people after guidance and training, not much of which was required because of their own life experiences.

He believes that health problems are social problems, so that there should really only be a Ministry of Social Services, under which would be a Health Department. This certainly pleased the social science representatives in our group!

A mental health training component will be introduced into all courses.

Medical assistants will be trained in specialised areas - after an initial three year training, they work for three to five years, then can return for a further one or two years for psychiatric training, or three years for training in surgery.

Traditional healers

With respect to the traditional healers, the Minister told us that initially they had an ideological confrontation with them. Now the strategy is to empower the people to take responsibility and rewards for their own efforts, not, as the traditional healers would have them believe, the effort of supernatural forces! The answer has been to educate the people.

Recognising that well over half the population consult such healers, and the overriding need to reverse patterns of disease, traditional healers are now encouraged to form their own association, which is given recognition by the Ministry. This has enabled them to protect their own dignity and prestige.

He stressed the importance of family health, rather than just maternal and child health. This means that health education must be directed at the entire family (including the grandparents).

Health worker training

Historically the Ministry had been dependent on the South African Government for many things, including health training. (When they cut their ties with Rhodesia in 1976, this caused huge economic and social upheavals.) They no longer send people to South Africa for health training, but they do have some contact with institutions especially for vital areas such as AIDS research.

One of their most successful programmes has been in oral health. They send people to Canada for training as dental therapists who return to work in the health centres, which are linked to the concept of a health area. The level of oral health in these areas has improved dramatically over the last three years.

One month after independence, they abolished private practice. This of course created problems, but, the Minister said, retaining private practice also creates problems, so he suggested we have to choose which problems we want!

The delegation wishes to express its thanks, on behalf of all the conference delegates, to the Minister for not only the above discussions, but also for his enthusiastic support of, and participation in, the conference. ❑

Community-based health sciences education

The concepts of community-based health sciences education (CBHSE) were well received by the participants, who were also encouraged by the opportunity to interact and communicate with their colleagues from a wide variety of backgrounds and disciplines within the health and social sciences sectors.

It was generally accepted that there was an urgent need to integrate training across the health and social science disciplines and to make this training relevant and accountable to the needs of broad sections of our people.

There was much discussion concerning the need to involve the community at all stages in the planning, development and implementation of initiatives towards CBHSE programmes.

What emerged at the end of two hard-working days was that, whilst the need for CBSHE as noted above was accepted, the precise mechanisms for establishing programmes, and cooperation between programmes both in and outside the country were less well understood.

There emerged a dichotomy between the views of the politically active individuals and those working within established institutions towards the same goals for CBHSE, but who are less politically active. This highlighted the continuing need for the sort of dialogue that took place during the workshop. It became evident, though, that there should be encouragement of all individuals and units within institutions so that they can undergo a process of transformation.

Mechanisms were identified that exist within the Mass Democratic Movement, (such as the Centre for Development Studies health and social sciences commissions) that can be used to facilitate these processes. ❑

Resolution on community-based health sciences education

This Conference, noting

1. The encouraging and positive response of participants to the concepts of Community-Based Health Sciences Education (CBHSE), and that the successful implementation of CBHSE projects revolves around the three interconnected factors of community, educational establishment, and health care delivery system;
2. The need for institutions to become actively involved in progressive changes to the health care system;
3. The effectiveness of a communication process that involved groups and individuals from disparate backgrounds and areas within the health and social sciences sectors;
4. The urgent need to integrate training across the health and social sciences disciplines, and to make this training relevant and accountable to community needs;
5. The absolute need to involve the community at all stages in the planning, development, implementation and evaluation of community-based courses;

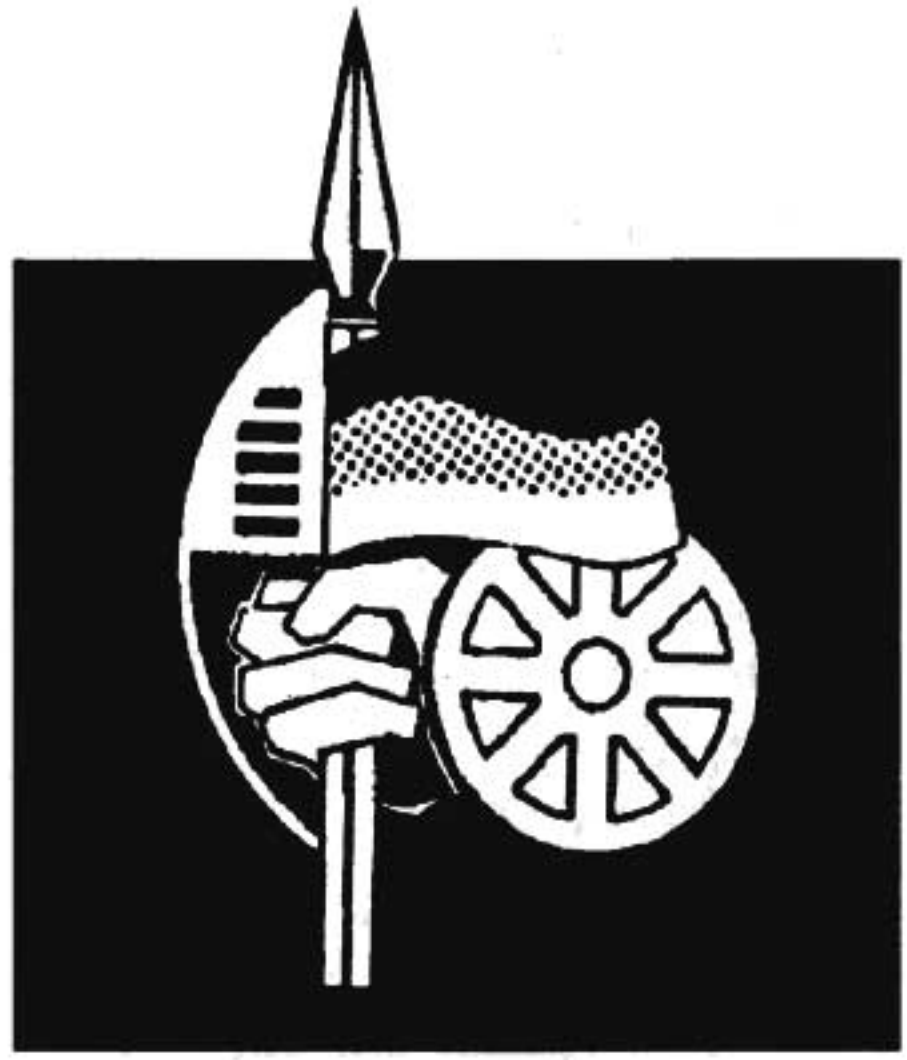
And recognising

1. The many advantages of establishing links with outside agencies possessing resources and expertise that will help to speed the process of implementation of initiatives towards CBHSE programmes;
2. The similar advantages that can accrue from linkages between programmes within institutions and organisations inside the country;
3. The imperative that all such linkages must be seen to advance the liberation struggle;
4. That the health and social sciences commissions within the Centre for Development Studies provide an ideal forum for consultation with all progressive organisations within the Mass Democratic Movement;

Hereby resolves

1. To identify, initiate and foster links with progressive individuals and units within established institutions within the country to facilitate the gradual, progressive conversions of those institutions;
2. To support cooperation between community-based health sciences education initiatives both inside and outside the country.
3. That the above two points are conditional on the strengthening of progressive organisations, and on the support of, and accountability to, structures within the Mass Democratic Movement.

Interview: ANC Health Department



Critical Health: When and why was the Health Secretariat established?
ANC: The secretariat was established in July 1977 in Dar-es-Salaam. After consultation with ANC members, it was agreed to form a medical structure that was to effectively, and in a more coordinated manner, deliver health care to the large number of South Africans who had come out as a result of the Soweto uprisings. Until then, health care was delivered on an ad-hoc basis, utilising the local health facilities and also the health personnel, mainly medical auxiliaries, who had been trained since 1960.

However, the host countries could no longer deal with the large numbers of refugees because of economic and financial constraints. It was also important to deliver health care to our community by way of demonstrating our ability to do so and also to foster our identity. In our favour was also the willingness of the international community to give support for us to implement our programmes and projects.

As the workload began to increase and the demands became varied, the Committee was enlarged and its name changed to the ANC Department of Health. This helped to emphasise that care was not only medical, but demands the full participation of other personnel.

CH: How does the Health Department relate to the broader ANC structure?
ANC: It is one of many departments of the ANC and falls under the Secretary General's Office. Although it has no immediate representation in the National Executive Committee (the highest decision-making body of the ANC), it is represented in all other decision-making bodies of the movement, including the army.

CH: What areas of work is the department involved in?
ANC: Broadly speaking, the objectives of the committee have been to:

- deliver care to our communities;
- disseminate information on the effects of apartheid on health and in so doing, further isolate South Africa;
- mobilise material and moral aid for the ANC;
- train health personnel for the ANC;
- arrange for training opportunities for ANC cadres;
- engage in an analysis of the political economy of health, looking at broader health issues, including the determinants of health;

In 1981, it was instrumental in the convening of the International Conference on Apartheid and Health in collaboration with the World Health Organisation (WHO). Also, members of the ANC Health Secretariat have served in one capacity or another in the workshops and seminars convened by the WHO, and the International Labour Organisation (ILO).

We run workshops on health related topics for health workers and members of the ANC in general.

In 1982, the Department formulated, together with SWAPO, a joint programme of action on environmental, mental, maternal and child health care, including the development of an essential drug list for the refugee settlement.

The Department has developed an AIDS programme, including an AIDS video and literature.

Research into policy options for an alternative health care system for a future South Africa has been undertaken on a limited scale.

CH: Has the ANC undertaken any health personnel development for a future health care system?
ANC: Personnel development has been problematic. One obvious discrepancy is that more doctors than nurses have been trained. The Health Department has run medical assistant courses by way of developing health resources. There was a need for personnel able to deliver primary health care and skilled enough to handle situations without doctors. The training of such mid-level medical assistants was a largely a response to the shortage of trained ANC personnel.

Tanzania had experience in developing such cadres and having looked at their curriculum, it was felt that it would fulfill our needs. In order to accommodate those cadres whose education levels were too low for this mid-level training, basic courses were run in the Frontline States. The cadres could then gain entry for mid-level training after doing one of these courses.

Another option explored was opening up training schools in the ANC settlement in Angola. One year upgrading course for people with no previous exposure to health practice was provided, which included basic sciences. The cadres would then be sent to the courses in Tanzania. The GDR ran similar programmes for SWAPO. Some cadres who started the mid-level course went on from there to study medicine.

A two year training course was available in Sweden for nurses. Cadres with

an interest in the course were chosen for this purpose. To undergo training as doctors, comrades were sent to the USSR, Bulgaria and Cuba, some went to Zambia and a few to Zimbabwe.

Others underwent training as social workers. Many of these cadres work in different departments in the ANC, not just in the Secretariat.

There has been a debate in the ANC about whether to open separate social service structures. A decision against this was taken because of the duplication of structures.

CH: To what extent have the traditional models of health care delivery and health worker hierarchies been challenged within the ANC health services?
ANC: Doctors do dominate to an extent and this has been problematic.

There is a level of contention between doctors and nurses in the ANC. Nurses are challenging the dominance of doctors within the movement. This challenge has resulted in a better understanding in relations but has involved acute confrontations. There is, however, a commitment to work through these issues.

In terms of portfolios within the Health Secretariat, some are nurses.

CH: How will the mid-level health workers be integrated into the existing South African services on returning home?
ANC: Our view is that we need to put pressure on South African bodies to recognise this training. Such personnel need to be placed somewhere. We need to look at their training curriculum and work out where they could fit in and/or how their training could be upgraded to meet requirements. Their integration must be discussed with progressive health workers as part of planning for repatriation.

CH: Many cadres have been trained in countries where the degrees are not accepted by the South African Medical & Dental Council (SAMDC). What is the ANC's approach to this situation?
ANC: Their eligibility for registration must be reconsidered by the SAMDC. The progressive movement in the country must initiate the steps necessary to take the issue up with the SAMDC.

CH: Has the ANC had contact in the past with organisations internally?
ANC: There has been contact with SAHWCO, NAMDA and NEHAWU. We have tried to get information on developments within the health sector in general but obviously this was not always easy to achieve.

CH: How do you envisage a relationship with internal health worker organisations in the future, given the unbanning of the ANC and the opening of local offices?
ANC: In view of there being relatively few people in the health team outside the country and many health workers internally will be joining the ANC, we are of the view that there should be health organisations operating independently of political organisations. Thus even people who do not politically identify with the ANC can still be organised progressively. Members of the health teams of the ANC will have to join these progressive formations. Possibly, this may help bring the various formations together. So in other words, the Health Secretariat of the ANC as presently constituted will have to come to an end. The ANC as a political organisation may need a subcommittee with a special focus on health related issues. Who is part of such a committee is open to discussion.

CH: How does the ANC envisage the structure of a future health system in South Africa?
ANC: Obviously we can only be very general in our answer here. The ANC is strongly in favour of a national health service and of a service with a strong bias towards the primary health care concept. The democratic state will have a duty to ensure that health services provision will reach out to those most in need. Resources will have to be put into this.

Democratic organisations have the urgent task to work together with the ANC, to map out a clear workable programme to ensure that we can achieve this.

CH: What problems should health and social service workers be preparing themselves for, with regard to returnees?
ANC: Some comrades are presently undergoing medical treatment for various problems and will need immediate follow up treatment on their return. Some of the comrades are disabled and their specific needs will have to be considered too.

Many comrades left the country many years ago and may need reorientation and social support for the change of environment.

Also to be considered is the situation in Natal - many returning comrades with families in this area do not know if their families have moved, or even if they are all alive. We must somehow anticipate the particular problems such comrades will face.

We will need to compile a list of all these comrades and the regions within South Africa to which they will be returning.

The ANC and progressive organisations in the country need to work out, in definite terms, which structures will be involved in the overall returnee issue and how to coordinate this process. The ANC must make a concrete breakdown of where these people will be going to, to assist structures to prepare.

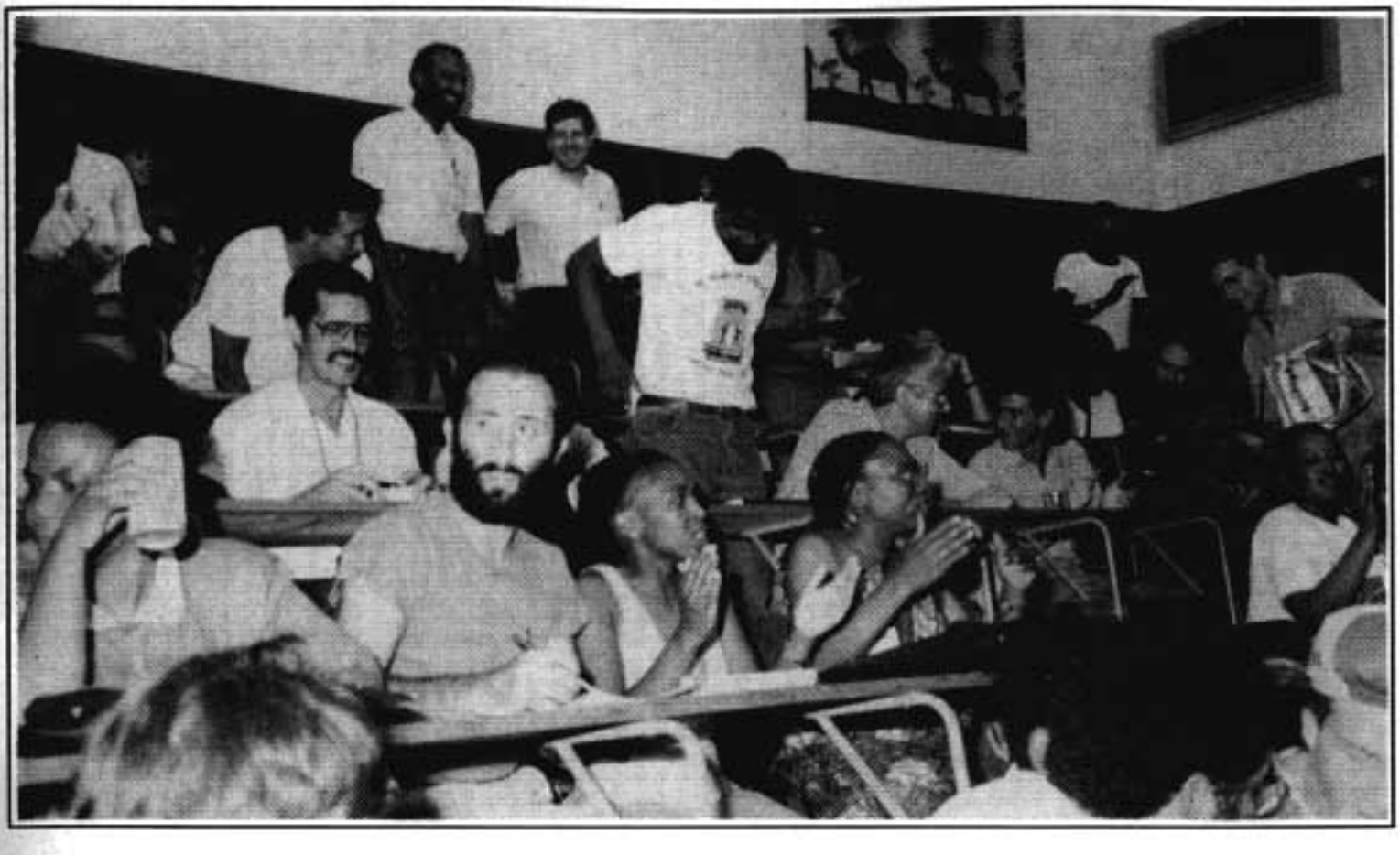
This we see as a task for all in the democratic movement and the decision of which structures to create must involve broad consultation.

CH: Any final comments?
ANC: Perhaps a comment on unity in the health sector. As much as there are differences between the progressive health organisations, there are a lot of things that bring them together - especially concerning the delivery of an equitable health service.

We should try everything possible to ensure that small organisational differences do not stand in the way of the broad tasks and responsibilities we as health workers face.

It should be stressed that, in our understanding, this unity can best be achieved as a result of common action from the lowest local level up, even before we can think of national unity. Unity should start on a local level.

Finally, as progressive health workers, our understanding of health is that it is the responsibility not only of health workers, but of the entire community and therefore, whatever way we structure ourselves, people must be actively involved and organised. We must ensure that our organisations at all times strengthen the structures of the community. ❑

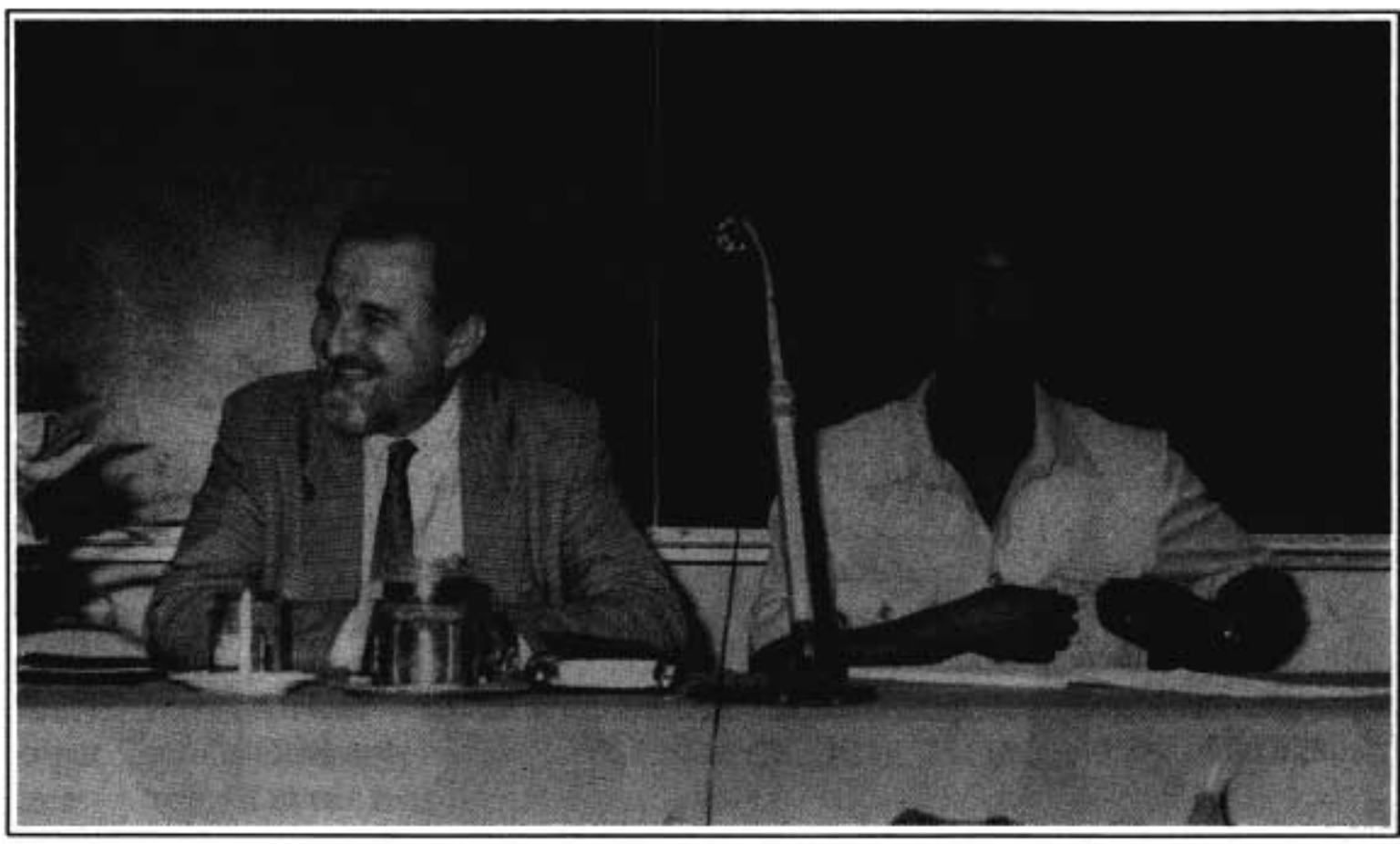


Delegates toyi-toyi between sessions in the lecture theatre of the Medical School of Maputo.

Overjoyed to meet Comrade Steve! Steve Tshwete of the ANC (NEC) addressed the conference.

Delegates met with Ms Garca Machel (centre).

Delegates from S.A. engage in intense discussions with members of the ANC and SACP .



Both Frelimo's Deputy Foreign Secretary (left) and the Minister of Health of Mozambique addressed the conference.

Not every minute was spent in intense debate! Delegates cool off in the evening.

Abbreviations

AIDS	Acquired Immuno-deficiency Syndrome
ANC	African National Congress
AZAPO	Azanian Peoples Organisation
CBHSE	Community-based Health Sciences Education
CHW	Community Health Workers
COSATU	Congress of South African Trade Unions
CSW	Concerned Social Workers
HIV	Human Immunodeficiency Virus
IMA	Islamic Medical Association
MASA	Medical Association of South Africa
MDM	Mass Democratic Movement
NAMDA	National Medical and Dental Association
NEHAWU	National Education, Health and Allied Workers Union
NHI	National Health Insurance
NHS	National Health Service
PAC	Pan Africanist Congress
PHC	Primary Health Care
PHCN	Primary Health Care Nurse
PPHCN	Progressive Primary Health Care Network
SABSWA	South African Black Social Workers Association
SAHWCO	South African Health Workers Congress
SAMDC	South African Medical and Dental Council
SANA	South African Nursing Association
SWAPO	South West African People's Organisation
TBVC	Transkei, Bophuthatswana, Venda, Ciskei ("homelands")
UDF	United Democratic Front
UK	United Kingdom
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation

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Critical Health aims to:

- provide ideas for roles that health workers can play in promoting a healthy society;
- show that good health is a basic right;
- provide a forum for the discussion of health related issues;
- provide insight into the political nature of health.

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